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	08/25/2025

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. (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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility's interdisciplinary team (IDT-a coordinated group of experts from several different fields who work together toward the care goals of the resident) failed to evaluate and assess residents mental and physical abilities for one of one sampled resident (Resident 1) to determine whether self-administering medications was clinically appropriate for the resident.Resident 1 was observed with five bottles of supplements at bedside which included vitamin C, calcium, vitamin D3, vitamin E and vitamin B12.This deficient practice had the potential to cause negative side effects to Resident 1's health.Findings: During a review of Residents 1's admission Record, the admission record indicated the resident was admitted to the facility on [DATE] with diagnoses including delusional disorders (a type of mental health condition in which a person cannot tell real from imagined), diabetes (blood sugar level to become too high), left and right eye blindness category 3 (means severe visual impairment that is worse than legal blindness, but can still perceive some light), and anemia (not having enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissues). During a review of Resident 1's History and Physical (H&P) dated 8/11/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), initiated 8/15/2025, the MDS was not completed until 8/25/2025. The MDS indicated Resident 1 required partial/moderate assistance (helper does less than half the effort) with toileting, and personal hygiene, and required substantial /maximal assistance (helper does more than half the effort) with bathing. The MDS indicated Resident 1 was frequently incontinent of urine, and occasionally incontinent of bowel. During a concurrent interview and record review on 8/25/2025 at 8:30 AM, with Resident 1 in Residents 1's room, Resident 1 had five bottles of supplements (vitamin C, calcium, vitamin D3, vitamin E and vitamin B12) at the right-side bedside table within reach to Resident 1. Resident 1 stated she had been taking the vitamins herself for years, and she was aware she had her vitamins at bedside. Resident 1 stated she sometimes had diarrhea (passing loose, watery stools), then stated being surrounded by a magnetic field and nonsensical things. During an interview on 8/25/2025 at 9:35 AM in Resident 1's room with Licensed Vocational Nurse (LVN) 1, LVN 1 stated she was not aware Resident 1 had the vitamin supplements at bedside, and she was not sure if Resident 1 was assessed prior to having the vitamin supplement at bedside. LVN 1 stated Resident 1 might consume too many vitamins, and it may not be good for Resident 1. During a concurrent interview and record review on 8/25/2025 at 10:30 AM, with the Director of Nurses (DON), Resident 1's electronic health record (EHR) dated from admission 8/8/2025 to present 8/25/2025 was reviewed. The record did not have an assessment or an evaluation from the IDT to determine if Resident 1 was clinically appropriate and safe to self-administer her supplements. The record also did not indicate a physician's order for Resident 1 to self-administer the supplements. The DON stated Resident 1 was not evaluated by the IDT nor by the medical doctor if Resident 1 was appropriate to have supplements at bedside. The DON stated the facility did not have any documentation of any type of assessment for Resident 1 regarding self-administering medications. The DON stated having the supplements by Resident 1's bedside and Resident 1 verbalizing she takes it herself had the potential to cause an overdose of the supplements that could affect her health. A review of the facility's policy and procedure (P&P) titled, Self-Administration of Medications, revised 12/2016, indicated a) Residents had the right to self-administer medications if the interdisciplinary team determined that it was clinically appropriate and safe for the resident to do so, b)as part of the overall evaluation, the staff and practitioner would assess each resident mental and physical abilities whether self-administering medications was clinically appropriate for the resident, c)the staff and practitioner would document their findings who are identified being able to self-administer medications, and d) nursing staff would review the self -administered medication recorded on each nursing shift and transfer pertinent information to the medication administration record (MAR) kept at the nursing station, appropriately noting that the doses were self-administered.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. (continued on next page)

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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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 1) had a complete comprehensive assessment of a resident's needs, strengths, goals, and preferences, using Resident 1's Minimum Data Set (MDS, a resident assessment tool) document, within 14 calendar days after admission, per facility policy. Resident 1 was admitted on [DATE] and the MDS was due to be completed on 8/21/2025 but was completed on 8/25/2025 (four days late).This deficient practice potentially resulted in Resident 1, who had left and right eye blindness category 3 (means severe visual impairment that is worse than legal blindness but can still perceive some light) verbalizing feeling of frustration about her care.Findings: During a review of Residents 1's admission Record, the admission record indicated the resident was admitted to the facility on [DATE] with diagnoses including delusional disorders (a type of mental health condition in which a person cannot tell reality from imagined), and category 3 left and right eye blindness. During a review of Resident 's History and Physical (H&P) dated 8/11/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's MDS initiated 8/15/2025, the MDS indicated a completion date of 8/25/2025. The MDS indicated Resident 1 required partial / moderate assistance (helper does less than half the effort) with toileting, and personal hygiene. The MDS indicated Resident 1 was frequently incontinent of urine, and occasionally incontinent of bowel. During a concurrent observation and interview on 8/25/2025 at 9:10 AM with Resident 1 and Certified Nurse Assistant (CNA) 1, in Resident 1's room, CNA 1 came to the room and asked Resident 1 for a diaper change. Resident 1 refused. Resident 1 stated, They do not know what to do with me. I am very frustrated with my care. CNA 1 stated when Resident 1 refused to have her diaper changed, she did not know what else to do. During a concurrent interview and record review on 8/25/2025 at 10:30 AM, with the Director of Nurses (DON), Resident 1's electronic health record (EHR) dated from admission 8/8/2025 to present 8/25/2025 was reviewed. The record did not have a plan of care for Resident 1's actual left and right eye blindness category 3. The DON stated that the facility did not have a plan of care for Resident 1's blindness maybe because the MDS initial comprehensive assessment was not completed thoroughly. The DON stated not having a plan of care for Resident 1's blindness may have contributed to her frustration about her care. During a concurrent interview and record review on 8/25/2025 at 11:25 AM, with MDS Nurse (MDSN) and the DON, Resident 1's electronic health records (EHR) under MDS summary (undated) was reviewed. The document indicated Resident 1 was admitted on [DATE] and the document must be completed by 8/21/2025. The MDSN stated she was the assessment coordinator for the facility, and Resident 1's MDS was not completed timely. The MDSN stated the MDS assessment was critical in capturing and addressing the patient's needs and modify it as needed. The DON stated since the facility did not have a timely full assessment of Resident 1, the facility was not able to address all her needs that potentially caused Resident 1 to be angry and frustrated with her care. A review of the facility's policy and procedure (P&P) titled, MDS Completion and Submission Timeframes, revised 7/2017, indicated; a) the facility would conduct and submit assessments in accordance with current federal and state submission timeframes, b) the assessment coordinator or designee was responsible for ensuring that resident assessments were submitted to CMS (a federal agency under the U.S. Department of Health and Human Services that provides health coverage for more than 160 million people through programs like Medicare, Medicaid, and the Children's Health Insurance Program) in accordance with current federal and state guidelines. A review of the facility's P&P titled, Resident Assessments, revised 7/2019, indicated a) a comprehensive assessment of every residents needs was made at intervals designated by OBRA (federal standards for nursing home care to protect residents' rights, safety, and quality of life) requirement, b) OBRA required assessments - conducted for all residents in the facility includes; Initial assessment (Comprehensive) - conducted within fourteen (14) days of the resident's admission to the facility, the result of the assessments were used to develop, review and revise the resident's comprehensive care plan.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1) received care consistent with professional standards of practice to prevent pressure injury (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence), when Resident 1, who was admitted with Moisture-Associated Skin Damage (MASD, skin irritation or breakdown caused by prolonged exposure to wetness from bodily fluids) to the buttocks extending to the groin area, did not have a weekly skin assessment, per facility policy.This deficient practice had the potential to result in worsening the MASD or infection and could negatively affect Resident 1's quality of life.Findings:During a review of Residents 1's admission Record, the admission record indicated the resident was admitted to the facility on [DATE] with diagnoses including diabetes (blood sugar level to become too high) and anemia (not having enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissues). During a review of Resident 's History and Physical (H&P) dated 8/11/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), initiated 8/15/2025, the MDS indicated a completion date of 8/25/2025. The MDS indicated Resident 1 required partial/moderate assistance (helper does less than half the effort) with toileting, and personal hygiene. The MDS indicated Resident 1 was frequently incontinent of urine and had occasional incontinence of bowel. During a review of Resident 1's Braden's Scale for Predicting Pressure Risk, dated 8/8/2025, the document indicated Resident 1 had a high risk for pressure injury. During a review of Resident 1's care plan for Actual Impairment to Skin Integrity of the buttocks extending to the groin area related to MASD dated 8/8/2025, the care plan interventions indicated to monitor/document location, size and treatment of skin injury, report abnormalities, failure to heal, signs of infection etc. and report to the doctor. During a concurrent interview and record review on 8/25/2025 at 10:30 AM, with the Director of Nurses (DON), Resident 1's electronic health record (EHR) dated from admission 8/8/2025 to present 8/25/2025 was reviewed. The record indicated Resident 1 had MASD upon admission but did not have a weekly skin assessment completed per policy. The DON stated Resident 1 did not have a weekly skin assessment for her MASD, that included location, size and if treatment was effective. The DON stated not having a weekly skin assessment of Resident 1's MASD had the potential for further skin breakdown. During an interview on 8/25/2025 at 2 PM with Treatment Nurse (TN) 1, TN 1 stated Resident 1 had MASD upon admission on [DATE], and there was no weekly assessment because it was missed. TN 1 stated it was very important to have a weekly assessment of Resident 1's MASD, due to the resident's occasional refusal of diaper change. TN 1 stated the weekly skin assessment would determine if the current treatment was working or not, and if the MD needed to be notified. A review of the facility's policy and procedure (P&P) titled, Prevention of Pressure Injuries, revised 4/2020, indicated the purpose was to provide information regarding identification of pressure injury factors and interventions to specific risk factors and to assess the resident on admission for existing pressure injury risk factors and repeat risk assessment weekly. The P&P indicated to evaluate, report and document potential changes in the skin, and to review the interventions and strategies for effectiveness on and ongoing basis.