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	09/16/2025

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. (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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement a person-centered comprehensive care plan to address the resident's medical and physical needs for one of three sampled residents (Resident 2), reviewed for pressure injury and prevention. Resident 2 who was admitted with a Stage 3 pressure injury (an open, full-thickness skin wound that extends into the fatty tissue but not into the muscle, bone, or tendon) on his sacrum (situated just above the buttocks) and a SDTPI (suspected deep tissue pressure injury) to the right and left heel, did not have a weekly treatment documentation from the facility's wound doctor (WMD) nor the treatment nurse (TN) of a risk assessment, that included measurements of each area of the skin breakdown. This deficient practice had the potential to result in the worsening of Resident 2's pressure injuries, by not having a wound doctor evaluate the pressure injury weekly and current treatments, which could negatively affect Resident 2's comfort and quality of life. Findings: During a review of Resident 2's admission Record, the admission Record indicated the resident was originally admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses that included metabolic encephalopathy (a brain dysfunction caused by an underlying condition), hemiplegia and hemiparesis (paralysis/weakness) following cerebral infarction (a blood clot or blockage restricts blood flow and oxygen to the brain, damaging brain cells) affecting the left non-dominant side, and diabetes mellitus (blood sugar is too high). During a review of Resident 2's facility document titled Skin Observation Tool dated 8/29/2025 (date of admission), the Skin Observation Tool indicated Resident 2 had a Stage 3 pressure injury (PI) on his sacrum and SDTPI on the right and left heel. During a review of Resident 2's History and Physical Examination (HPE), dated 8/31/2025, the H & P indicated Resident 2 had fluctuating capacity to understand and make decisions During a review of Resident 2's Care Plan (CP) for Stage 3 pressure Injury to the sacrum dated 8/29/2025, the Care Plan included the listed interventions a) Assess/record/monitor wound healing, measure length. with and depth where possible and report improvements and declines to the Medical Doctor (MD), b) weekly treatment documentation to include measurement of each area of skin breakdown, width, depth, type of tissue and exudate. During a review of Resident 2's care plan (CP) for SDTPI on left heel dated 8/29/2025, the Care Plan interventions included to: a) assess/record/monitor wound healing, measure length. with and depth where possible and report improvements and declines to Medical Doctor (MD), b) weekly treatment documentation to include measurement of each area of skin breakdown, width, depth, type of tissue and exudate. During a review of Resident 2's care plan (CP) for SDTPI on the right heel dated 8/29/2025, the Care Plan interventions included to: a) assess/record/monitor wound healing, measure length. with and depth where possible and report improvements and declines to the Medical Doctor (MD), b) weekly treatment documentation to include measurement of each area of skin breakdown, width, depth, type of tissue and exudate. During a review of Resident 2's facility document titled Braden Scale For Predicting Pressure Sore Risk dated 8/29/2025, the Braden Scale indicated Resident 2 was bedfast (confined to bed), slightly limited mobility, and moderately at risk for pressure sore. During a review of Resident 2's facility document titled Order Summary Report (OSR) dated 8/29/2025, indicated a physician's order for wound consult and follow up visit by skilled wound care weekly, day shift Thursday Skilled Wound Care (SWC) (company that sends wound MD to facilities for wound evaluation and treatment). During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool), dated 9/5/2025, the MDS indicated Resident 2's cognitive skills (ability to make daily decisions) were severely impaired. The MDS indicated Resident 2 required supervision or touching assistance (Helper provides verbal cues and or touching steadying) with eating, and substantial/maximal assistance (helper does more than half the effort) with bathing, toileting, personal hygiene and dressing. During an observation on 9/16/2025 at 11:30 AM while in Resident 2's room, Resident 2 was in bed on his back, with limited mobility, verbalizing words making little or no sense. During a concurrent interview and record review, on 9/16/2025, at 2:30 PM, with Treatment Nurse (TN) 1, the (undated) facility binder for Skilled Wound Care (SWC) Communication Log was reviewed, the binder did not have a weekly assessment from WMD or TN 1 of Resident 2's Stage 3 PI on the sacrum area, and the SDTPI on Resident 2's right and left heel. TN 1 stated he did not have a weekly assessment of Resident 2's PI ‘s because he forgot to tell the WMD. TN 1 stated Resident 2 PI's were not reported to the WMD for evaluation, management and treatment and was not evaluated weekly by the WMD as per the plan of care. TN 1 stated, Resident 2 missed two weekly assessments, on 9/4/2025 and 9/11/2025. TN 1 stated it