

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055360	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/24/2025
NAME OF PROVIDER OR SUPPLIER  Oakpark Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 9166 Tujunga Canyon Blvd Tujunga, CA 91042	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>38549</p> <p>Based on observation, interview, and record review, the facility failed to ensure Licensed Vocational Nurse 1 (LVN 1) knocked on a resident's door before entering the room for one (Resident 25) out of one sampled resident investigated under the care area of dignity.</p> <p>This deficient practice violated the resident's right to be treated with respect and dignity, which had the potential to affect the resident's sense of self-worth and self-esteem.</p> <p>Findings:</p> <p>During a review of Resident 25's Admission Record, the Admission Record indicated the facility originally admitted the resident on 3/28/2024 and readmitted the resident on 12/3/2024 with diagnoses including Parkinsonism (a term used to describe a group of movement disorders that share similar symptoms to Parkinson's disease [a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements]).</p> <p>During a review of Resident 25's Minimum Data Set (MDS - a resident assessment tool), dated 4/1/2025, the MDS indicated the resident had severely impaired cognitive (thought processes) skills for daily decision making and maximal assistance from staff for most activities of daily living (ADLs - activities such as bathing, dressing, and toileting a person performs daily).</p> <p>On 4/22/2025 at 8:03 a.m., during an observation of medication administration, observed LVN 1 enter Resident 25's room multiple times without first knocking on the door.</p> <p>On 4/22/2025 at 8:50 a.m., during an interview, LVN 1 verified that she did not knock on Resident 25's door before entering the room to administer medications.</p> <p>On 4/24/2025 at 8:27 a.m., during an interview, the Director of Nursing (DON) stated that staff should knock on residents' doors before entering the room because the facility is their home. The DON stated it was a dignity issue if staff failed to knock on residents' doors before entering the room because it could make the resident feel uncomfortable or violate their privacy.</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
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's policy and procedure titled, Quality of Life - Dignity, last reviewed on 10/30/2024, the policy and procedure indicated that each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feeling of self-worth and self-esteem. Residents are treated with dignity and respect at all times. Residents' private space and property are respected at all times. Staff are expected to knock and request permission before entering residents' rooms.</p>

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<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>47883</p> <p>Based on interview and record review, the facility failed to develop a comprehensive person-centered care plan (a document that summarizes a resident's needs, goals, and care/treatment) for one of five sampled residents (Resident 36) addressing Resident 36 being positive for extended spectrum beta-lactamase (ESBL- enzymes [proteins that help speed up metabolism] produced by bacteria that make them resistant to antibiotic) producing Escherichia coli (E. coli- type of bacteria that can cause food-borne illness [food poisoning]).</p> <p>This deficient practice had the potential to result in failure to deliver the necessary care and services.</p> <p>Findings:</p> <p>During a review of Resident 36's Admission Record, the Admission Record indicated the facility admitted the resident on 6/3/2022 and readmitted the resident on 3/22/2023 with diagnoses that included chronic obstructive pulmonary disease (a lung diseases that block airflow and make it difficult to breathe), urinary tract infection (UTI- an infection in any part of the urinary system), and atrial fibrillation (a heart condition that causes an irregular and often abnormally fast heart rate).</p> <p>During a review of Resident 36's Minimum Data Set (MDS - a resident assessment tool) dated 3/25/2025, the MDS indicated the resident had a moderately impaired cognition (mental abilities, including remembering things, making decisions, concentrating, or learning) and required substantial assistance from staff for toileting hygiene, shower, dressing and personal hygiene.</p> <p>During a review of Resident 36's Urine Culture Result (a lab test that examines a urine sample to see if there are any bacteria) dated 3/24/2025, the Urine Culture Result indicated Resident 36 was positive for ESBL producing E. coli.</p> <p>During a review of Resident 36's Surveillance Data Collection Form (a systematic collection of data to track infection which is collected when a resident has certain signs and symptoms that could be a bacterial infection) dated 3/24/2025, the Surveillance Data Collection Form indicated Resident 36's urinalysis (UA - urine test to examine the physical, chemical, and microscopic examination of urine) was positive for ESBL and Resident 36 was on antibiotic (a medication that fights bacterial infection) therapy and contact precautions (a measure taken to prevent the spread of germs through direct or indirect contact with a person or their environment) per protocol.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 4/23/2025 at 11:14 a.m., with the Infection Preventionist (IP), reviewed Resident 36's nursing progress note dated 3/25/2025 and care plans from 3/24/2025 to 4/23/2025. The IP stated Resident 36's nursing progress note dated 3/25/2025 indicated that urine culture and sensitivity lab results were faxed to the physician with new orders for Augmentin (antibiotic) for five (5) days and Flagyl (antibiotic) for four (4) days for UTI positive for ESBL. The IP stated that according to the facility policy, there should have been an Interdisciplinary Team (IDT- a group of health care professionals with various areas of expertise who work together toward the goals of the residents' care plan) care plan meeting conducted to address Resident 36's change of condition regarding Resident 36's UTI positive for ESBL and develop a person-centered care plan.</p> <p>During an interview on 4/24/2025 at 11 a.m., with the Director of Nursing (DON), the DON stated that a care plan should be created to reflect Resident 36's change of condition regarding UTI positive for ESBL. The DON stated that this deficient practice placed Resident 36 at risk of not receiving the necessary care and services.</p> <p>During a review of the facility's policy and procedure titled, Care Planning- Interdisciplinary Team, last reviewed on 10/2024, the policy and procedure indicated, Comprehensive, person-centered care plans are based on resident assessments and developed by an interdisciplinary team.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44309</b></p> <p>Based on interview, and record review the facility failed to update and revise a resident's care plan (a document outlining a detailed approach to care customized to an individual resident's need) after a change of condition (COC-an improvement or worsening of a patient's condition which was not anticipated) on 3/4/2025, for one of three sampled residents (Resident 21) reviewed under the Accidents care area.</p> <p>This deficient practice had the potential to result in Resident 21 receiving inadequate care and supervision at the facility.</p> <p>Findings:</p> <p>During a review of Resident 21's Admission Record (face sheet), the Admission Rrecord indicated that the facility originally admitted the resident on 8/18/2021 and readmitted on [DATE], with diagnoses including Parkinsonism (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), ataxic gait (when a person is walking in an abnormal, uncoordinated, or unsteady manner), and unspecified dementia (a progressive state of decline in mental abilities).</p> <p>During a review of Resident 21's Minimum Data Set (MDS- a resident assessment tool) dated 3/29/2025, the MDS indicated the resident's cognitive skills (the brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated that Resident 21 required staff partial/moderate assistance (helper does less than half the effort) for toileting hygiene, and showering/bathing. The MDS further indicated that Resident 21 required staff supervision for oral hygiene, upper and lower body dressing, and personal hygiene.</p> <p>During a review of Resident 21's Change of Condition (COC-an improvement or worsening of a patient's condition which was not anticipated) Interact Assessment form dated 3/4/2025, the COC assessment form indicated that the resident had pain in his right shoulder.</p> <p>During a review of Resident 21's Physician Order dated 3/4/2025, the order indicated to take a stat (immediate) X-ray (a type of electromagnetic radiation that can be used to create images of the inside of the body) of the resident's right shoulder.</p> <p>During a review of Resident 21's potential for pain care plan initiated on 1/10/2025, the care plan indicated interventions to administer medications as ordered by the physician, notify the physician if the medications are ineffective, and to position the resident in his most comfortable position.</p> <p>(continued on next page)</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 4/22/2025 at 3:00 p.m., with the Director of Nursing (DON), Resident 21's care plans and COC forms were reviewed. The DON stated Resident 21 had a COC for right shoulder pain on 3/4/2025, and his right shoulder X-ray revealed no fracture. The DON stated Resident 1's risk for pain care plan was initiated on 1/30/2024 and last reviewed/revised on 4/9/2025. The DON stated Resident 21's risk for pain care plan was not reviewed and revised after his change of condition on 3/4/2025. The DON stated residents' care plans are required to be reviewed or revised after change of condition. The DON stated the purpose of reviewing and re-evaluating the care plans is to check the effectiveness of the care plan interventions and make sure all the pertinent information and intervention regarding residents' care are included in the care plan. The DON stated the potential outcome of not reviewing/revising a resident's care plan after change of condition is inadequate care and supervision of the resident.</p> <p>During a review of the facility's Policy and Procedure (P&amp;P) titled Care Plans, Comprehensive Person-Centered, last reviewed on 10/30/2025, the P&amp;P indicated that the Interdisciplinary Team must review and update the care plans when there has been a significant change in the resident's condition.</p> <p>During a review of the facility's Policy and Procedure (P&amp;P) titled Change in a Resident's Condition or Status, last reviewed on 10/30/2025, the P&amp;P indicated that a significant change of condition is a major decline or improvement in the resident's status that requires interdisciplinary review and/or revision to the care plans.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 44309</p> <p>Based on interview, and record review the facility failed to ensure a resident received treatment and care in accordance with professional standards of practice by:</p> <ol style="list-style-type: none"> <li>1. Failing to rotate (a method to ensure repeated injections are not administered in the same area) insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) injection sites for one of one sampled resident (Resident 4).</li> </ol> <p>This failure had the potential to result in bruising, pain, and/or lipodystrophy (lump or accumulation of fatty tissue under skin) to Resident 4.</p> <ol style="list-style-type: none"> <li>2. Failing to follow the hold parameters for amiodarone (a medication to prevent and treat arrhythmia [a fast or irregular heartbeat]) as ordered by the physician for one of five sampled residents (Resident 16) investigated for unnecessary medications.</li> </ol> <p>This deficient practice had the potential to cause complications such as irregular heart rhythm that could require hospitalization to Resident 16.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. During a review of Resident 4's Admission Record (face sheet), the admission record indicated the facility originally admitted the resident on 6/27/2020, and readmitted on [DATE], with diagnoses including type two diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), unspecified dementia (a progressive state of decline in mental abilities), and dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed).</li> </ol> <p>During a review of Resident 4's Minimum Data Set (MDS - a resident assessment tool) dated 2/28/2025, the MDS indicated that the resident's cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated that Resident 4 required staff substantial/maximal assistance (helper does more than half the effort) for eating, oral hygiene, toileting hygiene, showering/bathing, upper and lower body dressing, and putting on/taking off footwear. The MDS further indicated that Resident 4 was taking hypoglycemic (a group of drugs used to help reduce the amount of sugar present in the blood) medication which was considered a high-risk drug class medication (a group of medications that pose a significantly elevated risk of causing harm to patients if used incorrectly or if errors occur during administration).</p> <p>During a review of Resident 4's physician Order Summary Report (physician orders) dated 10/30/2023, the order summary report indicated to administer insulin Glargine solution (a long-acting insulin injected once daily that provides a consistent, steady level of insulin throughout the day) 100 units per milliliters (unit/ml, a unit of fluid volume), inject 12 units subcutaneous (SQ- injecting in the fatty layer of the skin) at bedtime for DM. The order summary report further indicated to hold the medication if resident's blood sugar is less than 120 milligrams per deciliter (mg/dl-unit of measurement [ normal range for a diabetic according to American Diabetes Association: 80-130 mg/dl]).</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 4's physician Order Summary Report dated 1/31/2024, the order summary report indicated to administer insulin lispro (a rapid-acting insulin: a medicine used to control the amount of sugar in the blood of patients with diabetes. It starts to work very quickly, and you take it before meals to stop your blood sugar (BS) from going too high) subcutaneously as per sliding scale ( the increasing administration of the insulin dose based on the blood sugar level) before meals and at bedtime: if the resident's blood sugar level is 151-200 mg/dl, administer 2 units of insulin (a unit of measurement for insulin), BS 201-250 mg/dl=4 units, BS 251-300 mg/dl=6 units, BS 301-350 mg/dl= 8 units, BS 351-400 mg/dl=10 units, and BS 401-500 mg/dl=12 units of insulin and notify the physician.</p> <p>During a review of Resident 4's care plan (a document outlining a detailed approach to care customized to an individual resident's need) for skin discoloration in the abdomen, initiated on 8/19/2024, the care plan indicated a goal that the resident will have no skin discoloration due to insulin injections in the next three months. The care plan interventions were to rotate insulin injection sites regularly, inspect injection sites for signs of hematoma (a localized collection of blood), and to assess the resident's skin condition daily.</p> <p>During a review of Resident 4's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) from 4/1/2025-4/25/2025, the MAR indicated that Resident 4 received insulin lispro SQ as follows:</p> <p>4/3/2025 at 9:00 p.m. - abdomen - left lower quadrant (LLQ-the lower left section of the abdomen, below the belly button)</p> <p>4/4/2025 at 9:00 p.m. - abdomen - left lower quadrant (LLQ)</p> <p>4/10/2025 at 4:30 p.m. - abdomen - left lower quadrant (LLQ)</p> <p>4/11/2025 at 4:30 p.m. - abdomen - left lower quadrant (LLQ)</p> <p>4/15/2025 at 9:00 p.m. - abdomen - left lower quadrant (LLQ)</p> <p>4/16/2025 at 4:30 p.m. - abdomen - left lower quadrant (LLQ)</p> <p>4/16/2025 at 9:00 p.m. - abdomen - left lower quadrant (LLQ)</p> <p>4/17/2025 at 4:30 p.m. - abdomen - left lower quadrant (LLQ)</p> <p>4/18/2025 at 4:30 p.m. - abdomen - left lower quadrant (LLQ)</p> <p>4/17/2025 at 9:00 p.m. - abdomen - left lower quadrant (LLQ)</p> <p>During a review of Resident 4's MAR from 4/1/2025-4/25/2025, the MAR indicated that Resident 4 received insulin Glargine SQ as follows:</p> <p>4/17/2025 at 9:00 p.m. - abdomen - left lower quadrant (LLQ)</p> <p>4/18/2025 at 9:00 p.m. - abdomen - left lower quadrant (LLQ)</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 4/25/2025 at 11:27 a.m., with Licensed Vocational Nurse 2 (LVN 2), Resident 4's MAR for April 2025 was reviewed. LVN 2 stated that licensed staff did not rotate Resident 4's injection sites on 4/10/2025, 4/11/2025, and from 4/15/2024 through 4/17/2025. LVN 2 stated the sites of insulin administration should be rotated to prevent damage to the resident's skin tissues.</p> <p>During a concurrent interview and record review on 4/25/2025 at 2:30 p.m., with the Director of Nursing (DON), Resident 4's care plans and MAR for April 2025 were reviewed. The DON stated that based on the documentation in Resident 4's MAR for April 2025, the resident received insulin injections in the LLQ of her abdomen on 4/10/2025, 4/11/2025, and from 4/15/2024 through 4/17/2025. The DON stated licensed staff should rotate residents' insulin injection sites every time they administer insulin, to prevent skin tissue damage. The DON stated one of the interventions in Resident 4's care plan for skin discoloration in the abdomen, was to rotate the insulin injection sites. The DON stated licensed staff should implement residents' care plan interventions. The DON stated the potential outcome of not rotating insulin injection sites is the development of bruise and hardened areas under the resident's skin that can reduce insulin absorption.</p> <p>During a review of the facility's Policy and Procedure (P&amp;P) titled, Insulin Administration, last reviewed on 10/30/2024, the P&amp;P indicated insulin may be injected to SQ tissue of the upper arm, and the anterior or lateral areas of the thighs and abdomen. Injection sites should be rotated, preferably within the same general area (abdomen, thigh, upper arm).</p> <p>During a review of the facility's Policy and Procedure (P&amp;P) titled, Adverse Consequences and Medication Errors, last reviewed on 10/30/2024, the P&amp;P indicated that a medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician's order, manufacturer specifications, or professional standards and principles of the professional (s) providing service.</p> <p>47883</p> <p>2. During a review of Resident 16's Admission Record, the Admission Record indicated the facility admitted the resident on 1/22/2021 and readmitted the resident on 7/17/2023, with diagnoses including compression fracture of second lumbar vertebra (condition when second bone [one of the vertebrae] has collapsed or broken, making it shorter than normal), paroxysmal atrial fibrillation (a heart condition that causes an irregular and often abnormally fast heart rate), and chronic obstructive pulmonary disease (a group of diseases that cause airflow blockage and breathing-related problems).</p> <p>During a review of Resident 16's Minimum Data Set (MDS - a resident assessment tool), dated 1/30/2025, the MDS indicated the resident had intact cognition (undamaged mental abilities, including remembering things, making decisions, concentrating, or learning) and required moderate- to -maximal assistance from staff for most activities of daily living (ADLs - activities such as bathing, dressing, and toileting a person performs daily).</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 16's Order Summary Report, the Order Sumamry Report indicated an order dated 10/24/2024 for amiodarone oral tablet 200 milligrams (mg- metric unit of measurement, used for medication dosage and/or amount) give one tablet by mouth in the morning for arrhythmia, hold if systolic blood pressure (SBP - the pressure in the arteries when the heart contracts and pumps blood throughout the body, normal reference range is less than or equal to 120 millimeters of mercury [mm Hg]) is less than (&lt;) 100 mm Hg or pulse (the number of heart beats per minute) is less than 60.</p> <p>During a review of Resident 16's 4/2025 MAR, covering the dates 4/1/2025 through 4/23/2025, the MAR indicated Resident 16 was given amiodarone when the SBP was &lt; than 100 mm Hg for the following date:</p> <p>4/6/2025 10 a.m. 97/58 mm Hg.</p> <p>4/13/2025 10 a.m. 99/64 mm/Hg.</p> <p>During a concurrent interview and record review with Director of Nursing (DON) on 4/24/2025 at 11 a.m., reviewed Resident 16's 4/2025 MAR. The DON confirmed that LVN 5 signed that the amiodarone was given to Resident 16 on the following dates and times:</p> <p>4/6/2025 10 a.m. 97/58 mm Hg.</p> <p>4/13/2025 10 a.m. 99/64 mm/Hg.</p> <p>During an interview with the Director of Nursing (DON) on 4/24/2025 at 11 a.m., the DON stated the amiodarone should not have been given on the above dates and times. The DON stated a blood pressure should be checked first and if it is out of parameters for medication administration, medication should be held in blister pack and marked as held on blister pack and MAR. The DON stated Resident 16 could be at risk for irregular heart rhythm and resulting complications from this deficient practice</p> <p>During a review of the facility's recent policy and procedure titled, Administering Medications, last reviewed on 10/2025, the policy indicated: Medications are administered in a safe and timely manner, and as prescribed . If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administrating the medication shall initial, and circle MAR space provided for the drug and dose.</p> <p>During a review of the facility's recent policy and procedure titled, Adverse Consequences and Medication Errors, last reviewed on 10/2025, the policy indicated: A Medications erro is defined as the preparation or administration of drug or biological which is not in accordance with physician orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38549</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents' low air loss mattresses (LALM - a medical-grade mattress designed to prevent and treat pressure injuries [localized damage to the skin and/or underlying tissue usually over a bony prominence]) were set correctly for three (Residents 5, 17, and 37) out of four sampled residents investigated under the care area of pressure ulcer (PU)/injury.</p> <p>These deficient practices had the potential to place the residents at increased risk for discomfort and development of pressure ulcers/injuries.</p> <p>Findings:</p> <p>a. During a review of Resident 5's Admission Record, the Admission Record indicated the facility originally admitted the resident on 9/7/2022 and readmitted the resident on 9/14/2023 with diagnoses including dementia (a progressive state of decline in mental abilities), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and muscle wasting and atrophy (a wasting away or decrease in size of muscle tissue, leading to reduced muscle mass and strength).</p> <p>During a review of Resident 5's Minimum Data Set (MDS - a resident assessment tool), dated 3/26/2025, the MDS indicated the resident had moderately impaired cognition (thought processes) and required moderate assistance from staff for most activities of daily living (ADLs - activities such as bathing, dressing, and toileting a person performs daily). The MDS also indicated the resident was at risk of developing pressure ulcers/injuries.</p> <p>During a review of Resident 5's physician's order, dated 12/24/2024, the order indicated to provide the resident with an LALM for wound management and prevention. The order indicated for the charge nurse to check for proper placement and function every shift.</p> <p>On 4/21/2025 at 9:01 a.m., during a concurrent observation and interview, observed Resident 5 awake in bed. The resident's LALM was set to 350 pounds (lbs - unit of measurement). When asked what the resident's current weight was, Licensed Vocational Nurse 2 (LVN 2) stated 119 lbs. LVN 2 stated that the resident's LALM was set incorrectly.</p> <p>On 4/24/2025 at 8:27 a.m., during an interview with the Director of Nursing (DON), the DON stated that the LALM should have been set according to the resident's weight in order to prevent the occurrence or reoccurrence of pressure injuries. The DON stated that if the LALM was not set correctly, then it could potentially have a negative effect on the resident's skin. The DON stated the resident could potentially develop a pressure injury.</p> <p>During a review of the LALM manufacturer's guide, the manufacturer's guide indicated that the patient comfort pressure ranges from soft (level 0 = 8 +/- 4 millimeters of mercury [mmHg - unit of measurement]) to firm (level 9 = 32 +/- 4 mmHg). The comfort control LED displays the patient comfort pressure levels from 0 to 9 and provides a guide to the caregiver to set approximate comfort pressure level depending on the patient weight.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility's policy and procedure titled, Pressure Ulcers/Skin Breakdown - Clinical Protocol, last reviewed on 10/30/2024, the policy and procedure indicated that the physician will order pertinent wound treatments, including pressure reduction surfaces, wound cleansing and debridement approaches, dressings (occlusive, absorptive, etc.) and application of topical agents.</p> <p>b. During a review of Resident 17's Admission Record, the Admission Record indicated the facility originally admitted the resident on 10/7/2023 and readmitted the resident on 11/1/2023 with diagnoses including muscle wasting, atrophy, and dementia.</p> <p>During a review of Resident 17's MDS, dated [DATE], the MDS indicated the resident had severely impaired cognition and required maximum assistance from staff for most ADLs. The MDS also indicated the resident was at risk of developing pressure ulcers/injuries.</p> <p>During a review of Resident 17's physician's order, dated 1/25/2025, the order indicated that the resident may use an LALM for wound prevention and skin management. The order indicated for charge nurses to check for proper placement and function every shift.</p> <p>During a review of Resident 17's care plan (a document that outlines a patient's specific healthcare needs, goals, and the care team's plan to address them) for risk for unavoidable development and worsening of pressure injury, initiated on 7/8/2024, the care plan indicated to provide the resident with an LALM as ordered.</p> <p>On 4/21/2025 at 8:51 a.m., during a concurrent observation and interview, observed Resident 17 asleep in bed. Observed a sticker on the LALM indicating to set it to 100 - 150 lbs. Observed the LALM set to 50 lbs. When asked what the resident's current weight was, LVN 2 stated the resident currently weighed 128 lbs. LVN 2 stated the resident used to have a pressure ulcer, and the LALM was used for maintenance and to prevent the development of future PUs.</p> <p>On 4/24/2025 at 8:27 a.m., during an interview with the Director of Nursing (DON) the DON stated that the LALM should have been set according to the resident's weight in order to prevent the occurrence or reoccurrence of pressure injuries. The DON stated that if the LALM was not set correctly, then it could potentially have a negative effect on the resident's skin. The DON stated the resident could potentially develop a pressure injury.</p> <p>During a review of the LALM manufacturer's guide, the manufacturer's guide indicated that the pressure of the mattress can be adjusted by choosing the patients' corresponding weight setting using the weight setting buttons.</p> <p>During a review of the facility's policy and procedure titled, Pressure Ulcers/Skin Breakdown - Clinical Protocol, last reviewed on 10/30/2024, the policy and procedure indicated that the physician will order pertinent wound treatments, including pressure reduction surfaces, wound cleansing and debridement approaches, dressings (occlusive, absorptive, etc.) and application of topical agents.</p> <p>44309</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>c. During a review of Resident 37's Admission Record (face sheet), the Admission Record indicated that the facility originally admitted the resident on 6/7/2024 and readmitted on [DATE], with diagnoses including unspecified dementia (a progressive state of decline in mental abilities), difficulty in walking, dysphagia (difficulty swallowing), and epilepsy (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness).</p> <p>During a review of Resident 37's Minimum Data Set (MDS- a resident assessment tool) dated 3/29/2025, the MDS indicated the resident's cognitive skills (the brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated that Resident 37 required staff partial/moderate assistance (helper does less than half the effort) for toileting hygiene, showering/bathing, upper and lower body dressing, and personal hygiene. The MDS further indicated that Resident 37 was at risk for developing pressure ulcers and had pressure reducing devices for bed and chair.</p> <p>During a review of Resident 37's physician Order Summary Report (physician orders) dated 1/16/2025, the Order Summary Report indicated to apply a LALM for wound management and prevention. The Order Summary Report further indicated for charge nurses to check for proper placement and functioning of the LALM during every shift.</p> <p>During a review of Resident 37's care plan (a document outlining a detailed approach to care customized to an individual resident's need) for pressure sore risk, the care plan indicated a goal that the resident will not develop pressure ulcer for the next three months. The care plan interventions were to use pressure-reducing devices, position and reposition the resident very two hours, and handle the resident gently during care.</p> <p>During a review of Resident 37's care plan for LALM, initiated on 1/16/2025, the care plan indicated a goal that the resident will have comfort and protection of her skin. The care interventions were to monitor and document for the effectiveness of device, monitor the device for good working conditions and ensure equipment is in working order.</p> <p>During a review of Resident 37's Weight and Vitals Summary form, the form indicated that the resident weighed 108 pounds (lbs.- a unit of weight) on 4/2/2025.</p> <p>During a concurrent observation, and interview on 4/21/2025 at 9:27 a.m. with Registered Nurse 1 (RN 1) inside Resident 37's room, Resident 37 was observed in bed with a LALM set at 320. There was a sticker placed on the LALM machine that indicated the setting should be on 100. RN 1 stated that the purpose of the LALM is to prevent extra weight on the wound and the settings of the LALM are determined by the resident's weight. RN 1 stated that Resident 37's LALM setting should be at 100, based on the resident's weight. RN 1 stated that the facility's treatment nurse is responsible for the the LALM setting. RN 1 further stated that the potential outcome of an incorrect LALM setting is a delay in the wound healing or worsening of the pressure ulcer.</p> <p>During an interview on 4/24/2025 at 2:00 p.m. with the Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated that she (LVN 2) is working as a treatment nurse in the facility. LVN 2 stated that she places a sticker on the residents' LALM machines indicating the correct setting that the machine needs to be set at based on the residents' weights. LVN 2 states that the setting on Resident 37' LALM was incorrect. LVN 2 stated that an incorrect high setting of the LALM will place too much pressure on the resident's skin and can potentially cause discomfort, redness and risk for pressure injury.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 4/24/2025 at 2:00 p.m., with the Director of Nursing (DON), the DON stated that licensed staff are required to check and monitor residents' LALM placement, functioning and setting. The DON stated the LALM settings are determined by the resident's weight and the incorrect settings on the LALM is a deficient practice. The DON stated the potential outcome is discomfort and worsening of the resident's pressure ulcer.</p> <p>During review of the facility's Policy and Procedure m(P&amp;P) titled Prevention of Pressure Injuries, reviewed 10/30/2024, the P&amp;P indicated that review and select medical devices with consideration to the ability to minimize tissue damage, including size, shape, its application and ability to secure the device, monitor regularly for comfort and signs of pressure related injury. For prevention measures associated with specific devices, consult clinical practice guidelines.</p> <p>During a review of Med-Aire Assure 5 Air + Foam Base Alternating Pressure and Low Air Loss Mattress System User Manual, the manual indicated to turn the pressure adjust knob to set a comfortable pressure level by using the weight scale as a guide.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47883</p> <p>Based on observation, interview, and record review, the facility failed to:</p> <ol style="list-style-type: none"> <li>1. Ensure a resident who was at high risk for falls had floor mats (a cushioning pad placed by a resident's bed to absorb the force of a resident falling) as ordered by the physician for one out of four sampled residents (Resident 36) investigated for accidents and hazards.</li> <li>2. Implement accident risks and hazard intervention by failing to place a personal alarm (a device with sensors that will alarm when a resident stands up unassisted to help prevent falls by alerting staff) on a resident's wheelchair as ordered by the physician for one of four (Resident 21) reviewed under accidents care area.</li> </ol> <p>This deficient practice had the potential to place Resident 21 at risk for recurrent falls and injuries.</p> <ol style="list-style-type: none"> <li>3. Provide a resident with a bed alarm (a device designed to alert caregivers when a patient attempts to get out of bed) as ordered by the physician for one (Resident 17) out of four sampled residents investigated under the care area of accidents.</li> </ol> <p>This deficient practice had the potential to place the resident at increased risk for falls and subsequent injury.</p> <ol style="list-style-type: none"> <li>4. Ensure that Licensed Vocational Nurse 1 (LVN 1) did not leave medications unattended and out of eyesight at the resident's bedside for one (Resident 25) out of four sampled residents investigated under the care area of accidents.</li> </ol> <p>This deficient practice had the potential to place residents at increased risk of accidentally ingesting medications and experiencing side effects.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. During a review of Resident 36's Admission Record, the Admission Record indicated the resident was admitted to the facility on [DATE] and readmitted the resident on 3/22/2023, with diagnoses that included but not limited to, chronic obstructive pulmonary disease (a lung diseases that block airflow and make it difficult to breathe), urinary tract infection (an infection in any part of the urinary system), and atrial fibrillation (a heart condition that causes an irregular and often abnormally fast heart rate).</li> </ol> <p>During a review of Resident 36's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 3/25/2025, the MDS indicated the resident had a moderately impaired cognition (a moderate damaged mental abilities, including remembering things, making decisions, concentrating, or learning) and required substantial assistance from staff for toileting hygiene, shower, dressing and personal hygiene. The resident was dependent on two or more helpers for bed mobility ana was using manual wheelchair with some help for indoor mobility.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 36's Order Summary Report, dated 4/1/2025, the Order Summary Report indicated an order dated 03/23/2023, for floor mat on right side of the bed for fall risk management every shift.</p> <p>During a review of Resident 36's Fall Risk Evaluation, dated 3/19/2025, the Fall Risk Evaluation indicated a total score of 13, indicating that the resident was at high risk for falls.</p> <p>During a review of Resident 36's Care Plan for Falls Risk, initiated 3/14/2025, the care plan indicated that Resident 36 is at risk for falls due to dementia (decline in mental ability severe enough to interfere with daily functioning/life), difficulty walking, left sided weakness and muscle wasting atrophy.</p> <p>During a review of Resident 36's Care Plan for Falls Risk, initiated 3/14/2025, the care plan indicated that Resident 36 requires special needs device such as floor mat on right side.</p> <p>During an observation and interview with Resident 36 and Certified Nursing Assistant 3 (CNA 3) on 4/23/2025 at 2:36 p.m., inside Resident 36's room, observed Resident 36 in bed with no floor mat next to the bed. CNA 3 stated she never saw a floor mat at Resident 36's bedside.</p> <p>During an interview with the Director of Nursing (DON) on 4/24/2025 at 11:00 a.m., the DON stated that Resident 36 should have a floor mat at bed side due to high risk for falls. The DON stated that not providing a floor mat may increase Resident 36's risk for complications resulting from falls.</p> <p>During a review of the facility's policy and procedure titled Fall and Fall Risk, managing, last reviewed on 10/30/2024, the policy and procedure indicated: Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risk and causes to try to prevent the resident from falling and to try to minimize complications from falling.</p> <p>44309</p> <p>2. During a review of Resident 21's Admission Record (face sheet), the Admission Record indicated that the facility originally admitted the resident on 8/18/2021 and readmitted on [DATE], with diagnoses including Parkinsonism (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), ataxic gait (when a person is walking in an abnormal, uncoordinated, or unsteady manner), and unspecified dementia (a progressive state of decline in mental abilities).</p> <p>During a review of Resident 21's Minimum Data Set (MDS- a resident assessment tool) dated 3/29/2025, the MDS indicated the resident's cognitive skills (the brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated that Resident 21 required staff partial/moderate assistance (helper does less than half the effort) for toileting hygiene, and showering/bathing. The MDS further indicated that Resident 21 required staff supervision for oral hygiene, upper and lower body dressing, and personal hygiene.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 21's physician Order Summary Report (physician order) dated 1/10/2025, the order summary report indicated to apply personal alarm while in bed and in wheelchair to alert staff of unassisted transfer and ambulation. The order summary report further indicated to monitor use and placement of the alarm during very shift.</p> <p>During a review of Resident 21's Fall Risk assessment dated [DATE], the fall risk assessment indicated that Resident 21 had intermittent (comes and goes) confusion, had no falls in the past six months, and had balance problem while standing and walking. The fall risk assessment indicated that Resident 21 had a total score of 16 and a score of 10 or greater indicated the resident should be considered at high risk for potential falls.</p> <p>During a review of Resident 21's Fall Risk Care Plan initiated on 1/10/2025, the care plan indicated a goal that the resident will not have any fall incidents for three months. The care plan interventions were to monitor the resident, maintain a safe environment, place the resident's bed in a low position and apply personal alarm on the resident's bed and wheelchair.</p> <p>During a review of Resident 21's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for 4/1/2025-4/21/2025, the MAR indicated that licensed staff monitored the use and placement of Resident 21's personal alarm in bed and on his wheelchair during every shift.</p> <p>During an observation on 4/21/2025 at 10:43 a.m., inside the facility's activity room, Resident 21 was observed sitting on his wheelchair. Resident 21's wheelchair did not have any personal alarm device attached to it.</p> <p>During a concurrent observation and interview on 4/21/2025 at 10:45 a.m., inside the activity room with the Activity Assistant (AA), Resident 21's wheelchair was observed. AA stated that there was no alarm placed on Resident 21's wheelchair. AA stated that she will notify Resident 21's charge nurse right away.</p> <p>During an interview on 4/21/2025 at 2:17 p.m., with the facility's Director of Nursing (DON), the DON stated staff should implement physician's orders for fall precautions. The DON stated Resident 21's physician ordered to apply a personal alarm on his bed and wheelchair to alert the staff of unassisted transfer and ambulation. However, staff did not place any alarm on Resident 21's wheelchair while he was sitting on it inside the activity room. The DON stated the potential outcome of not placing the alarm in the wheelchair as ordered is recurrent falls and injuries.</p> <p>During a review of the facility's Policy and Procedure (P&amp;P) titled Falls and Fall Risk, Managing, last reviewed 10/30/2024, the P&amp;P indicated that the staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factors of falls for each resident at risk or with a history of falls. Position-change alarms will not be used as the primary or sole interventions to prevent falls but rather will be used to assist the staff in identifying patterns and routines of the resident. The use of alarms will be monitored for efficacy and staff will respond to alarms in a timely manner. The staff will monitor and document each resident's response to interventions intended to reduce falling or risk factors.</p> <p>38549</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. During a review of Resident 17's Admission Record, the Admission Record indicated the facility originally admitted the resident on 10/7/2023 and readmitted the resident on 11/1/2023 with diagnoses including encephalopathy (a general term for any brain disease, damage, or malfunction that affects brain function or structure), muscle wasting and atrophy (the wasting away or decrease in size of muscle tissue, leading to reduced muscle mass and strength), and dementia (a progressive state of decline in mental activities).</p> <p>During a review of Resident 17's Minimum Data Set (MDS - a resident assessment tool), dated 1/15/2025, the MDS indicated the resident had severely impaired cognition (thought processes) and required maximum assistance from staff for most activities of daily living (ADLs - activities such as bathing, dressing, and toileting a person performs daily).</p> <p>During a review of Resident 17's Fall Risk Assessment, dated 1/24/2025, the assessment indicated the resident was at high risk for falls.</p> <p>During a review of Resident 17's Change of Condition (COC - any significant alteration in a patient's health or well-being compared to their baseline or usual state)/Interact Assessment Form, dated 1/24/2025, the form indicated that the resident had an unwitnessed fall.</p> <p>During a review of Resident 17's physician's order, dated 1/25/2025, the order indicated to provide the resident with a personal alarm while in bed and in the wheelchair to alert staff of unassisted transfer and ambulation. Monitor use and placement every shift.</p> <p>During a review of Resident 17's care plan (a document that outlines a patient's specific healthcare needs, goals, and the care team's plan to address them) for her unwitnessed fall, initiated on 1/24/2025, the care plan indicated for the resident to have a bed alarm.</p> <p>On 4/22/2025 at 10:48 a.m., during a concurrent observation and interview, observed Resident 17 asleep in bed with no bed alarm. Certified Nursing Assistant 1 (CNA 1) confirmed that the resident did not have a bed alarm on her bed.</p> <p>On 4/24/2025 at 8:27 a.m., during an interview, the Director of Nursing (DON) stated it was important for Resident 17 to have a bed alarm while in bed because it would alert staff if the resident tried to get out of bed unassisted. The DON stated if there was no bed alarm, then the resident could potentially suffer an injury if she were to have a fall.</p> <p>During a review of the facility's policy and procedure titled, Falls and Fall Risk, Managing, last reviewed on 10/30/2024, the policy and procedure indicated that based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling.</p> <p>4. During a review of Resident 25's Admission Record, the Admission Record indicated the facility originally admitted the resident on 3/28/2024 and readmitted the resident on 12/3/2024 with diagnoses including Parkinsonism (a term used to describe a group of movement disorders that share similar symptoms to Parkinson's disease [a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements]).</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 25's MDS, dated [DATE], the MDS indicated the resident had severely impaired cognitive skills for daily decision making and maximal assistance from staff for most ADLs.</p> <p>On 4/22/2025 at 8:30 a.m., during an observation of medication administration for Resident 25, observed Licensed Vocational Nurse 1 (LVN 1) pour out arginaid (a nutritional supplemental powder designed to support wound healing) and lactobacillus (a type of probiotic). Observed LVN 1 leave the medications unattended and out of eyesight behind the privacy curtain at the resident's bedside while LVN 1 went back to the medication cart to retrieve a gastrostomy tube (g-tube - a feeding tube that is surgically inserted directly into the stomach through the abdominal wall) syringe.</p> <p>On 4/22/2025 at 8:50 a.m., during an interview, LVN 1 verified that she had left the medications unattended and out of eyesight at the resident's bedside.</p> <p>On 4/24/2025 at 8:27 a.m., during an interview, the DON stated it was important for licensed nurses to ensure that medications were not left unattended or out of eyesight because residents can have unauthorized access to the medication and accidentally ingest it.</p> <p>During a review of the facility's policy and procedure titled, Administering Medications, last reviewed on 10/30/2024, the policy and procedure indicated that, during administration of medications, medications are kept locked when out of sight of the medication nurse or aide.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 44309</p> <p>Based on observation, interview, and record review, the facility failed to:</p> <p>1. Ensure that a resident received oxygen as ordered by the physician for one of four sampled residents (Resident 37) reviewed under the respiratory care area.</p> <p>This deficient practice had the potential to place Resident 37 at risk for complications associated with oxygen therapy.</p> <p>2. Ensure a resident's oxygen tubing (a flexible tube used to deliver oxygen from an oxygen tank) was labeled with the date of when it was last changed for three (Resident 37, Resident 16 and Resident 13) out of four sampled residents investigated under the care area of respiratory care.</p> <p>This deficient practice had the potential to place the residents at increased risk of developing an infection.</p> <p>Findings:</p> <p>1. and 2.a During a review of Resident 37's Admission Record (face sheet), the admission record indicated that the facility originally admitted the resident on 6/7/2024 and readmitted on [DATE], with diagnoses including unspecified dementia (a progressive state of decline in mental abilities), difficulty in walking, dysphagia (difficulty swallowing), and epilepsy (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness).</p> <p>During a review of Resident 37's Minimum Data Set (MDS- a resident assessment tool) dated 3/29/2025, the MDS indicated the resident's cognitive skills (the brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated that Resident 37 required staff partial/moderate assistance (helper does less than half the effort) for toileting hygiene, showering/bathing, upper and lower body dressing, and personal hygiene.</p> <p>During a review of Resident 37's physician Order Summary Report (physician orders) dated 1/7/2025, the order indicated to administer oxygen at two liters per minute via nasal cannula (NC-a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) as needed for shortness of breath (SOB). The order summary report indicated to titrate (to carefully adjust the amount of oxygen a patient receives to achieve a specific, target level of oxygen saturation in the blood) the oxygen level up to five liters per minute to keep the resident's oxygen saturation (a measurement of how much oxygen your blood is carrying compared to its maximum capacity-for healthy adults, normal oxygen saturation is between 95% and 100%) at 92% and /or greater. The order summary report further indicated for charge nurses to change the oxygen tubing and humidifier every week on Wednesdays during evening shift.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 37's care plan (a document outlining a detailed approach to care customized to an individual resident's need) for oxygen, initiated on 1/7/2025, the care plan indicated a goal that the resident will have no SOB in three months. The care plan interventions were to administer oxygen as per physician order, monitor the resident's oxygen saturation and change oxygen tubing once a week or as needed.</p> <p>During a concurrent observation, and interview on 4/21/2025 at 9:27 a.m., with Registered Nurse 1 (RN 1) inside Resident 37's room, Resident 37 was observed in bed receiving oxygen greater than 5 liters per minute via NC. Resident 37's oxygen tubing and humidifier did not have labels including the date and time of when they were last changed. RN 1 stated that Resident 37's oxygen tubing and humidifier did not have a label with the date and time of when they were last changed. RN 1 stated that staff should change oxygen tubing once a week on Wednesdays. RN 1 stated the potential outcome of not changing the resident's oxygen tubing and humidifier once per week as ordered by the physician is placing the resident at risk for infection. RN1 further stated that Resident 37 was receiving oxygen greater than 5 liters per minute via NC. RN 1 stated that she (RN 1) is unsure of how much oxygen Resident 37 is required to receive. However, delivering too much oxygen via NC may be harmful to Resident 37. RN 1 stated that she is going to check the physician's order for Resident 37's oxygen administration.</p> <p>During a concurrent interview and record review on 4/21/2025 at 10:10 a.m., with RN 1, Resident 37's physician orders were reviewed. RN 1 stated that Resident 37's physician ordered to administer oxygen at two liters per minute via NC as needed and titrate the oxygen level up to five liters per minute. RN 1 stated that based on her observation, Resident 37 was receiving more than five liters per minute via NC. RN 1 stated that the potential outcome of giving too much oxygen to the resident is difficulty breathing and harm to the resident's nostrils.</p> <p>During an interview on 4/25/2025 at 2:10 p.m., with the Director of Nursing (DON), the DON stated licensed staff should implement physician orders for administration of oxygen to residents. The DON stated the potential outcome of administering oxygen more than the physician's ordered flow rate via NC is difficulty breathing and harm to the resident. The DON stated that staff should change the oxygen tubing and humidifier once per week as ordered by the physician and label the tubing with the date and time it was changed. The DON stated the potential outcome of not changing and labeling the oxygen tubing and humidifier is the increased risk of infection for the residents.</p> <p>During a review of the facility's Policy and Procedure (P&amp;P) titled Oxygen Administration, last reviewed on 10/30/2024, the P&amp;P indicated the purpose of this guideline is to provide guidelines for safe oxygen administration. Verify that there is a physician's order for this procedure. Review the physician's order or facility protocol for oxygen administration.</p> <p>38549</p> <p>2.b. During a review of Resident 13's Admission Record, the Admission Record indicated the facility originally admitted the resident on 4/16/2024 and readmitted the resident on 2/6/2025 with diagnoses including congestive heart failure (CHF - a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing), and an acquired absence of part of the lungs.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 13's Minimum Data Set (MDS - a resident assessment tool), dated 2/12/2025, the MDS indicated the resident had moderately impaired cognition (thought processes) and required moderate assistance from staff for most activities of daily living (ADLs - activities such as bathing, dressing, and toileting a person performs daily). The MDS also indicated the resident was on continuous oxygen therapy.</p> <p>During a review of Resident 13's physician's order, dated 2/10/2025, the order indicated to provide oxygen via nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) at 1 liter per minute (LPM - unit of measurement) continuously for COPD exacerbation every shift. May titrate up to 3 LPM to keep oxygen saturation 88 - 94%.</p> <p>During a review of Resident 13's care plan (a document that outlines a patient's specific healthcare needs, goals, and the care team's plan to address them) for needs continuous oxygen use, initiated on 2/6/2025, the care plan indicated to change the oxygen tubing once a week or as needed.</p> <p>On 4/21/2025 at 9:14 a.m., during a concurrent observation and interview, observed Resident 13 asleep in bed. Observed the resident with a nasal cannula on. CNA 2 stated he could not find a label on the resident's oxygen tubing indicating when it was last changed.</p> <p>On 4/23/2025 at 1:58 p.m., during an interview, the Infection Preventionist (IP) stated that residents' oxygen tubing should be changed at least once a week, and it should be labeled with the date of when it was last changed. The IP stated it was important to change oxygen tubing regularly because microorganisms can grow on it and cause infection.</p> <p>During a review of the facility's policy and procedure titled, Oxygen Administration, last reviewed on 10/30/2024, the policy and procedure indicated that after completing the oxygen setup or adjustment, the date and time that the procedure was performed should be recorded.</p> <p>47883</p> <p>2.c. During a review of Resident 16's Admission Record, the Admission Record indicated the facility admitted the resident on 1/22/2021 and readmitted the resident on 7/17/2023 with diagnoses including compression fracture of second lumbar vertebra (condition when second bone [one of the vertebrae] has collapsed or broken, making it shorter than normal), paroxysmal atrial fibrillation (a heart condition that causes an irregular and often abnormally fast heart rate), and chronic obstructive pulmonary disease (a group of diseases that cause airflow blockage and breathing-related problems).</p> <p>During a review of Resident 16's Minimum Data Set (MDS - a resident assessment tool), dated 1/30/2025, the MDS indicated the resident had intact cognition (undamaged mental abilities, including remembering things, making decisions, concentrating, or learning) and required moderate- to -maximal assistance from staff for most activities of daily living (ADLs - activities such as bathing, dressing, and toileting a person performs daily).</p> <p>During a review of Resident 16's Care Plan (a document outlining a detailed approach to care customized to an individual resident's need), dated 4/17/2025, the care plan indicated that resident needs oxygen for chronic obstructive pulmonary disease (COPD). The care plan interventions indicated to change tubing once a week or as needed.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 16's physician's orders, dated 4/17/2025, the orders indicated to:</p> <ol style="list-style-type: none"> <li>1. Provide oxygen via nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) at 2 liter per minute (LPM - unit of measurement) as needed, may titrate to 5 LMP to keep oxygen saturation to 92%and/or higher for shortness of breath( SOB) as needed.</li> <li>2. Charge nurse to change oxygen tubing every week on Wednesday every evening shift.</li> </ol> <p>During concurrent observation and interview on 4/21/2025, at 9:07 a.m. with Registered Nurse 1 (RN 1), Resident 16 was observed in his bed receiving oxygen via nasal cannula at 2 LPM. RN 1 stated that the oxygen tubing was not labeled with the date when it was last changed.</p> <p>During an interview on 4/23/2025 at 11:14 a.m. with the Infection Preventionist (IP), the IP stated that the oxygen tubing should be changed in the facility every week and as needed and labeled with date when it was last changed to prevent respiratory infection.</p> <p>During an interview on 4/24/2025 at 11a.m. with the Director of Nursing (DON), the DON stated the the oxygen tubing had to be labeled with the date when it was last changed to prevent a possibility of respiratory infection to Resident 16.</p> <p>During a review of the facility's policy and procedure titled, Oxygen Administration, last reviewed on 10/30/2024, the policy and procedure indicated that after completing the oxygen setup or adjustment, the date and time that the procedure was performed should be recorded.</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>44309</p> <p>Based on observation, interview and record review, the facility failed to ensure that its medication error rate was less than five (5) percent (%), due to 10 medication errors observed out of 41 total opportunities (error rate of 24.39 %) affecting two of five randomly selected residents (Resident 151 and Resident 25). The medication errors were as follows:</p> <ol style="list-style-type: none"> <li>1. Licensed Vocational 3 (LVN 3) administered Resident 151 carvedilol (a medication used to treat hypertension [HTN-high blood pressure]) and pancrelipase (a medication to improve digestion of foods in adults who cannot digest food normally) at the time specified by the physician's order</li> <li>2. Licensed Vocational Nurse 1 (LVN 1) mixed together eight crushed medications and administered them all at once via gastrostomy tube (g-tube - a feeding tube that is surgically inserted directly into the stomach through the abdominal wall) to Resident 25.</li> </ol> <p>These failures had the potential for Residents 25 and 151 to experience adverse medication effects (unwanted, uncomfortable, or dangerous effects that medication may have) and the potential to result in the residents' health and well-being to be negatively impacted.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. During a review of Resident 151's Admission Record (face sheet), the admission record indicated that the facility admitted the resident on 4/8/2025, with diagnoses including personal history of malignant neoplasm of pancreas (a type of cancer that develops when cells in the pancreas grow out of control and form a tumor), difficulty walking, and hypertensive heart disease (a condition where heart problems arise due to long-standing high blood pressure) with heart failure (a condition where the heart muscle is weakened and cannot pump enough blood to meet the body's needs).</li> </ol> <p>During a review of Resident 151's Minimum Data Set (MDS- a resident assessment tool) dated 4/14/2025, the MDS indicated that the resident's cognitive skills (brain's ability to think, read, learn, reason, express thoughts, and make decisions) for daily decision making was intact (decisions consistent/reasonable). The MDS indicated that Resident 151 required staff supervision for oral hygiene, toileting hygiene, showering/bathing, upper and lower body dressing, personal hygiene, and putting on/taking off footwear.</p> <p>During a review of Resident 151's Physician Order dated 4/11/2025, the order summary report indicated to administer carvedilol oral tablet, 3.125 milligrams (mg-a unit of measure of mass), one tablet by mouth two times a day (BID) for HTN. The physician order indicated to hold the medication if the resident's Systolic Blood Pressure (SBP- the upper number in a blood pressure reading, representing the pressure in the arteries when heart beats and pumps the blood out) is less than 110 millimeters of mercury (mmHg-unit of measurement). The physician order indicated to administer carvedilol with breakfast and dinner.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 151's physician Order Summary Report (physician orders) dated 4/8/2025, the order summary report indicated to administer pancrelipase oral capsule 12000-38000 unit, give two capsules by mouth three times a day for digestive aid. The order summary report further indicated to administer pancrelipase with meals.</p> <p>During a review of Resident 151's Medication Administration Record (MAR- a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) from 4/12/2025-4/22/2025, the MAR indicated that Resident 151 received carvedilol 3.125 mg twice daily at 7:30 a.m., and 5:30 p.m.</p> <p>During a review of Resident 151's MAR from 4/12/2025-4/22/2025, the MAR indicated that Resident 151 received Pancrelipase 12000-38000 unit, two capsules three times a day at 7:30 a.m., 12:30 p.m., and 5:30 p.m.</p> <p>During an observation of the medication administration on 4/23/2025 at 8:30 a.m., with Licensed Vocational Nurse 3 (LVN 3), Resident 151 was observed walking in the hallway with the physical therapist. Resident 151 approached the surveyor and stated that he did not receive his carvedilol and pancrelipase this morning. Resident 151 stated that he completed his breakfast around 8:00 a.m., and he should have taken pancrelipase before his breakfast for the medication to be effective. Resident 151 stated that taking Pancrelipase after he completed his breakfast would not help him with his digestion.</p> <p>During a concurrent interview and record review on 4/23/2025 at 8:37 a.m. with LVN 3 at Resident 151's bedside, LVN 3 stated that Resident 151's carvedilol and Pancrelipase were scheduled for administration at 7:30 this morning. LVN 3 stated that Resident 151's physician's order indicated to administer carvedilol and Pancrelipase at 7:30 a.m. with breakfast. LVN 3 stated breakfast is usually delivered around 7:30 a.m. LVN 3 stated per facility policy, there was a 60-minute window for medication administration and LVN 3 will administer carvedilol and Pancrelipase later than that timeframe. LVN 3 stated that carvedilol was scheduled to be administered at 7:30 a.m. with breakfast to prevent stomach discomfort and increase the absorption of the medication. LVN 3 stated Pancrelipase was scheduled to be administered at 7:30 a.m. with food to help Resident 151 digest his food. LVN 3 stated that a delay in medication administration is considered a medication error. LVN 3 stated she should check with the Director of Nursing (DON) regarding administering carvedilol and Pancrelipase later than the prescribed time.</p> <p>During an interview on 4/23/2025 at 8:59 a.m., with the DON, the DON stated she contacted Resident 151's physician and received a one-time administration order for carvedilol and Pancrelipase. The DON stated that licensed nurses are required to administer all medications in accordance with the time frame ordered by the physician. The DON stated medications are administered within one hour of their prescribed time. The DON stated that administering medications outside their prescribed time frame is considered a medication error and the potential outcome is that residents may not receive the benefits and therapeutic effects of the medication.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility's Policy and Procedure (P&amp;P) titled, Administering Medications, last reviewed on 10/30/2024, the P&amp;P indicated that medications are administered in a safe and timely manner, and as prescribed. The DON supervises and directs all personnel who administer medications and/or have related functions. Medications are administered in accordance with prescriber orders, including any required time frame. Medication administration times are determined by resident need and benefit, not staff convenience. Factors that are considered include enhancing optimal therapeutic effect of the medication, preventing potential medication or food interactions and honoring resident choices and preferences. Medications are administered within one hour of their prescribed time, unless otherwise specified.</p> <p>During a review of the facility's Policy and Procedure (P&amp;P) titled, Adverse Consequences and Medication Errors, last reviewed on 10/30/2024, the P&amp;P indicated that a medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician's order, manufacturer specifications, or professional standards and principles of the professional (s) providing service. Examples of medication errors include wrong time and /or failure to follow manufacturer instructions and/or accepted professional standards.</p> <p>38549</p> <p>2. During a review of Resident 25's Admission Record, the Admission Record indicated the facility originally admitted the resident on 3/28/2024 and readmitted the resident on 12/3/2024 with diagnoses including Parkinsonism (a term used to describe a group of movement disorders that share similar symptoms to Parkinson's disease [a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements]), gastrostomy status (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), and a history of urinary tract infections (UTI - an infection in the bladder/urinary tract).</p> <p>During a review of Resident 25's Minimum Data Set (MDS - a resident assessment tool), dated 4/1/2025, the MDS indicated the resident had severely impaired cognitive (thought processes) skills for daily decision making and maximal assistance from staff for most activities of daily living (ADLs - activities such as bathing, dressing, and toileting a person performs daily).</p> <p>During a review of Resident 25's physician's order, dated 4/7/2025, the order indicated to flush the resident's g-tube with 50 milliliters (ml - unit of measurement) of water before and after each med delivery.</p> <p>On 4/22/2025 at 8:17 a.m., during a med pass observation for Resident 25, observed LVN 1 mix together the following crushed medications in one cup:</p> <ol style="list-style-type: none"> <li>1. Aspirin (an antiplatelet medication) 81 milligram (mg - unit of measurement), ordered on 4/7/2025</li> <li>2. Carbidopa-levodopa (treats symptoms of Parkinson's disease) 25-250 mg, ordered on 4/7/2025</li> <li>3. Vitamin D ordered on 4/7/2025</li> <li>4. Nitrofurantoin (an antibiotic used to treat urinary tract infections) 50 mg, ordered on 4/7/2025</li> </ol> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Oakpark Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  9166 Tujunga Canyon Blvd Tujunga, CA 91042	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>5. Seligiline (treats symptoms of Parkinson's disease) 5 mg, ordered on 4/7/2025</p> <p>6. Senna (increases the activity of the intestines to cause a bowel movement) 8.6 mg, ordered on 4/7/2025</p> <p>7. Vitamin C 500 mg, ordered on 4/7/2025</p> <p>8. Zinc (mineral) 50 mg, ordered on 4/7/2025</p> <p>On 4/22/2025 at 8:22 a.m., during an observation, observed LVN 1 administer the crushed medications all at once via Resident 25's g-tube.</p> <p>On 4/22/2025 at 8:50 a.m., during an interview, LVN 1 confirmed that she mixed the eight medications together in one cup and administered them all at once.</p> <p>On 4/22/2025 at 1:49 p.m., during an interview, LVN 1 stated the facility's policy was to administer each crushed medication separately and flush with water between each medication. LVN 1 stated she did not do that. LVN 1 stated she put all the crushed medications together in one cup and administered them all together. LVN 1 stated it was important to administer each medication separately because, otherwise, there may be drug-to-drug interaction, which may render the medications less effective. LVN 1 stated it was also important to flush with water after giving each medication to ensure that the g-tube does not get clogged.</p> <p>On 4/24/2025 at 8:27 a.m., during an interview, the Director of Nursing (DON) stated it is the facility's policy to crush and administer medications separately when given through a g-tube in order to ensure that each medication is given in its entirety. The DON stated that, if mixed together, there is a potential for medications to interact with each other and render them less effective. The DON also stated it was important to make sure to flush with water after administering each medication to ensure that the g-tube does not get clogged. When asked if she considered what LVN 1 did to be a medication error, the DON stated that, technically, LVN 1 did not administer the medications correctly.</p> <p>During a review of the facility's policy and procedure titled, Adverse Consequences and Medication Errors, last reviewed on 10/30/2025, the policy and procedure indicated that a medication error is defined as the preparation or administration of drugs or biologicals which is not in accordance with the physician's orders, manufacturer's specifications, or accepted professional standards and principles of the professional providing services.</p> <p>During a review of the facility's policy and procedure titled, Administering Medications, last reviewed on 10/30/2025, the policy and procedure indicated that medications are administered in accordance with prescriber orders.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 44309</p> <p>Based on interview and record review the facility failed to ensure residents were free of any significant medication errors by failing to:</p> <p>1. Rotate (a method to ensure repeated injections are not administered in the same area) insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) injection sites for Resident 4.</p> <p>This deficient practice had the potential for adverse effect (unwanted, unintended results) of same site subcutaneous (SQ- injecting in the fatty layer of the skin) administration of insulin such as bruising, pain, and lipodystrophy (lump or accumulation of fatty tissue under skin).</p> <p>2. Ensure Resident 151 received carvedilol (a medication used to treat hypertension [HTN-high blood pressure]) and pancrelipase (a medication to improve digestion of foods in adults who cannot digest food normally) at a prescribed time as ordered by the physician.</p> <p>This deficient practice had the potential for Resident 151 to experience medication adverse effects.</p> <p>3. Ensure that Licensed Vocational Nurse 1 (LVN 1) did not mix together eight crushed medications and administer them all at once via gastrostomy tube (g-tube - a feeding tube that is surgically inserted directly into the stomach through the abdominal wall) for one (Resident 25) out of four sampled residents observed during the medication administration task.</p> <p>This deficient practice of administering medications contrary to accepted professional standards had the potential to negatively affect the health and well-being of Resident 25.</p> <p>This deficient practice of administering medications contrary to accepted professional standards had the potential to negatively affect the health and well-being of Resident 25.</p> <p>Findings:</p> <p>1. During a review of Resident 4's Admission Record (face sheet), the admission record indicated the facility originally admitted the resident on 6/27/2020, and readmitted on [DATE], with diagnoses including type two diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), unspecified dementia (a progressive state of decline in mental abilities), and dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed).</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 4's Minimum Data Set (MDS - a resident assessment tool) dated 2/28/2025, the MDS indicated that the resident's cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated that Resident 4 required staff substantial/maximal assistance (helper does more than half the effort) for eating, oral hygiene, toileting hygiene, showering/bathing, upper and lower body dressing, and putting on/taking off footwear. The MDS further indicated that Resident 4 was taking hypoglycemic (a group of drugs used to help reduce the amount of sugar present in the blood) medication which was considered a high-risk drug class medication (a group of medications that pose a significantly elevated risk of causing harm to patients if used incorrectly or if errors occur during administration).</p> <p>During a review of Resident 4's physician Order Summary Report (physician orders) dated 10/30/2023, the order summary report indicated to administer insulin Glargine solution (a long-acting insulin injected once daily that provides a consistent, steady level of insulin throughout the day) 100 units per milliliters (unit/ml, a unit of fluid volume), inject 12 units subcutaneous at bedtime for DM. The order summary report further indicated to hold the medication if resident's blood sugar is less than 120 milligrams per deciliter (mg/dl-unit of measurement [ normal range for a diabetic according to American Diabetes Association: 80-130 mg/dl]).</p> <p>During a review of Resident 4's physician Order Summary Report dated 1/31/2024, the order summary indicated to administer insulin lispro (a rapid-acting insulin: a medicine used to control the amount of sugar in the blood of patients with diabetes. It starts to work very quickly, and you take it before meals to stop your blood sugar (BS) from going too high) subcutaneously as per sliding scale ( the increasing administration of the insulin dose based on the blood sugar level) before meals and at bedtime: if the resident's blood sugar level is 151-200 mg/dl, administer 2 units of insulin (a unit of measurement for insulin), BS 201-250 mg/dl=4 units, BS 251-300 mg/dl=6 units, BS 301-350 mg/dl= 8 units, BS 351-400 mg/dl=10 units, and BS 401-500 mg/dl=12 units of insulin and notify the physician.</p> <p>During a review of Resident 4's care plan (a document outlining a detailed approach to care customized to an individual resident's need) for skin discoloration in the abdomen, initiated on 8/19/2024, the care plan indicated a goal that the resident will have no skin discoloration due to insulin injections in the next three months. The care plan interventions were to rotate insulin injection sites regularly, inspect injection sites for signs of hematoma (a localized collection of blood), and to assess the resident's skin condition daily.</p> <p>During a review of Resident 4's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) from 4/1/2025-4/25/2025, the MAR indicated that Resident 4 received insulin lispro SQ as follows:</p> <p>4/3/2025 at 9:00 p.m. - abdomen - left lower quadrant (LLQ-the lower left section of the abdomen, below the belly button)</p> <p>4/4/2025 at 9:00 p.m. - abdomen - left lower quadrant (LLQ)</p> <p>4/10/2025 at 4:30 p.m. - abdomen - left lower quadrant (LLQ)</p> <p>4/11/2025 at 4:30 p.m. - abdomen - left lower quadrant (LLQ)</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4/15/2025 at 9:00 p.m. - abdomen - left lower quadrant (LLQ)</p> <p>4/16/2025 at 4:30 p.m. - abdomen - left lower quadrant (LLQ)</p> <p>4/16/2025 at 9:00 p.m. - abdomen - left lower quadrant (LLQ)</p> <p>4/17/2025 at 4:30 p.m. - abdomen - left lower quadrant (LLQ)</p> <p>4/18/2025 at 4:30 p.m. - abdomen - left lower quadrant (LLQ)</p> <p>4/17/2025 at 9:00 p.m. - abdomen - left lower quadrant (LLQ)</p> <p>During a review of Resident 4's MAR from 4/1/2025-4/25/2025, the MAR indicated that Resident 4 received insulin Glargine SQ as follows:</p> <p>4/17/2025 at 9:00 p.m. - abdomen - left lower quadrant (LLQ)</p> <p>4/18/2025 at 9:00 p.m. - abdomen - left lower quadrant (LLQ)</p> <p>During a concurrent interview and record review on 4/25/2025 at 11:27 a.m., with Licensed Vocational Nurse 2 (LVN 2), Resident 4's MAR for April 2025 was reviewed. LVN 2 stated that licensed staff did not rotate Resident 4's injection sites on 4/10/2025, 4/11/2025, and from 4/15/2024 through 4/17/2025. LVN 2 stated the sites of insulin administration should be rotated to prevent damage to the resident's skin tissues.</p> <p>During a concurrent interview and record review on 4/25/2025 at 2:30 p.m., with the Director of Nursing (DON), Resident 4's care plans and MAR for April 2025 were reviewed. The DON stated that based on the documentation in Resident 4's MAR for April 2025, the resident received insulin injections in the LLQ of her abdomen on 4/10/2025, 4/11/2025, and from 4/15/2024 through 4/17/2025. The DON stated licensed staff should rotate residents' insulin injection sites every time they administer insulin, to prevent skin tissue damage. The DON stated that the failure to rotate the insulin administration site is considered a medication administration error. The DON stated the potential outcome of not rotating insulin injection sites is the development of bruise and hardened areas under the resident's skin that can reduce insulin absorption.</p> <p>During a review of the facility's Policy and Procedure (P&amp;P) titled, Insulin Administration, last reviewed on 10/30/2024, the P&amp;P indicated insulin may be injected to SQ tissue of the upper arm, and the anterior or lateral areas of the thighs and abdomen. Injection sites should be rotated, preferably within the same general area (abdomen, thigh, upper arm).</p> <p>During a review of the facility's Policy and Procedure (P&amp;P) titled, Adverse Consequences and Medication Errors, last reviewed on 10/30/2024, the P&amp;P indicated that a medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician's order, manufacturer specifications, or professional standards and principles of the professional (s) providing service.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2 . During a review of Resident 151's Admission Record (face sheet), the admission record indicated that the facility admitted the resident on 4/8/2025, with diagnoses including personal history of malignant neoplasm of pancreas (a type of cancer that develops when cells in the pancreas grow out of control and form a tumor), difficulty walking, and hypertensive heart disease (a condition where heart problems arise due to long-standing high blood pressure) with heart failure (a condition where the heart muscle is weakened and cannot pump enough blood to meet the body's needs).</p> <p>During a review of Resident 151's Minimum Data Set (MDS- a resident assessment tool) dated 4/14/2025, the MDS indicated that the resident's cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was intact (decisions consistent/reasonable). The MDS indicated that Resident 151 required staff supervision for oral hygiene, toileting hygiene, showering/bathing, upper and lower body dressing, personal hygiene, and putting on/taking off footwear.</p> <p>During a review of Resident 151's Physician Order dated 4/11/2025, the order summary report indicated to administer carvedilol oral tablet, 3.125 milligrams (mg-a unit of measure of mass), one tablet by mouth two times a day (BID) for HTN. The physician order indicated to hold the medication if the resident's Systolic Blood Pressure (SBP- the upper number in a blood pressure reading, representing the pressure in the arteries when heart beats and pumps the blood out) is less than 110 millimeters of mercury (mmHg-unit of measurement). The physician order indicated to administer carvedilol with breakfast and dinner.</p> <p>During a review of Resident 151's physician Order Summary Report (physician orders) dated 4/8/2025, the order summary report indicated to administer pancrelipase oral capsule 12000-38000 unit, give two capsules by mouth three times a day for digestive aid. The order summary report further indicated to administer pancrelipase with meals.</p> <p>During a review of Resident 151's Medication Administration Record (MAR- a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) from 4/12/2025-4/22/2025, the MAR indicated that Resident 151 received carvedilol 3.125 mg twice daily at 7:30 a.m., and 5:30 p.m.</p> <p>During a review of Resident 151's MAR from 4/12/2025-4/22/2025, the MAR indicated that Resident 151 received Pancrelipase 12000-38000 unit, two capsules three times a day at 7:30 a.m., 12:30 p.m., and 5:30 p.m.</p> <p>During an observation of the medication administration on 4/23/2025 at 8:30 a.m., with Licensed Vocational Nurse 3 (LVN 3), Resident 151 was observed walking in the hallway with physical therapist. Resident 151 approached the surveyor and stated that he did not receive his carvedilol and pancrelipase this morning. Resident 151 stated that he completed his breakfast around 8:00 a.m., and he was required to take pancrelipase before his breakfast for the medication to be effective. Resident 151 stated that taking Pancrelipase after he completed his breakfast would not help him with his digestion.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review on 4/23/2025 at 8:37 a.m. with LVN 3 at Resident 151's bedside, LVN 3 stated that Resident 151's carvedilol and Pancrelipase were scheduled for administration at 7:30 this morning. LVN 3 stated that Resident 151's physician's order indicated to administer carvedilol and Pancrelipase at 7:30 a.m. with breakfast. LVN 3 stated breakfast is usually delivered around 7:30 a.m. LVN 3 stated per facility policy, there was a 60-minute window for medication administration and LVN 3 will administer carvedilol and Pancrelipase later than that timeframe. LVN 3 stated that carvedilol was scheduled to be administered at 7:30 a.m. with breakfast to prevent stomach discomfort and increase the absorption of the medication. LVN 3 stated Pancrelipase was scheduled to be administered at 7:30 a.m. with food to help Resident 151 digest his food. LVN 3 stated that a delay in medication administration is considered a medication error. LVN 3 stated she should check with the facility's Director of Nursing (DON) regarding administering carvedilol and Pancrelipase later than the prescribed time.</p> <p>During an interview on 4/23/2025 at 8:59 a.m., with DON, the DON stated she contacted Resident 151's physician and received a one-time administration order for carvedilol and Pancrelipase. The DON stated that licensed nurses are required to administer all medications in accordance with the time frame ordered by the physician. The DON stated administering medications outside their prescribed time frame is considered medication error and the potential outcome is that residents may not receive the benefits and therapeutic effects of the medication.</p> <p>During a review of the facility's Policy and Procedure (P&amp;P) titled, Administering Medications, last reviewed on 10/30/2024, the P&amp;P indicated that medications are administered in a safe and timely manner, and as prescribed. The DON supervises and directs all personnel who administer medications and/or have related functions. Medications are administered in accordance with prescriber orders, including any required time frame. Medication administration times are determined by resident need and benefit, not staff convenience. Factors that are considered include enhancing optimal therapeutic effect of the medication, preventing potential medication or food interactions and honoring resident choices and preferences. Medications are administered within one hour of their prescribed time, unless otherwise specified.</p> <p>During a review of the facility's Policy and Procedure (P&amp;P) titled, Adverse Consequences and Medication Errors, last reviewed on 10/30/2024, the P&amp;P indicated that a medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician's order, manufacturer specifications, or professional standards and principles of the professional (s) providing service. Examples of medication errors include wrong time and /or failure to follow manufacturer instructions and/or accepted professional standard.</p> <p>38549</p> <p>3. During a review of Resident 25's Admission Record, the Admission Record indicated the facility originally admitted the resident on 3/28/2024 and readmitted the resident on 12/3/2024 with diagnoses including parkinsonism (a term used to describe a group of movement disorders that share similar symptoms to Parkinson's disease [a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements]), gastrostomy status (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), and a history of urinary tract infections (UTI - an infection in the bladder/urinary tract).</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 25's Minimum Data Set (MDS - a resident assessment tool), dated 4/1/2025, the MDS indicated the resident had severely impaired cognitive (thought processes) skills for daily decision making and maximal assistance from staff for most activities of daily living (ADLs - activities such as bathing, dressing, and toileting a person performs daily).</p> <p>During a review of Resident 25's physician's order, dated 4/7/2025, the order indicated to flush the resident's g-tube with 50 milliliters (ml - unit of measurement) of water before and after each med delivery.</p> <p>On 4/22/2025 at 8:17 a.m., during a med pass observation for Resident 25, observed LVN 1 mix together the following crushed medications in one cup:</p> <ol style="list-style-type: none"> <li>1. Aspirin (an antiplatelet medication) 81 milligram (mg - unit of measurement), ordered on 4/7/2025</li> <li>2. Carbidopa-levodopa (treats symptoms of Parkinson's disease) 25-250 mg, ordered on 4/7/2025</li> <li>3. Vitamin D ordered on 4/7/2025</li> <li>4. Nitrofurantoin (an antibiotic used to treat urinary tract infections) 50 mg, ordered on 4/7/2025</li> <li>5. Seligiline (treats symptoms of Parkinson's disease) 5 mg, ordered on 4/7/2025</li> <li>6. Senna (increases the activity of the intestines to cause a bowel movement) 8.6 mg, ordered on 4/7/2025</li> <li>7. Vitamin C 500 mg, ordered on 4/7/2025</li> <li>8. Zinc (mineral) 50 mg, ordered on 4/7/2025</li> </ol> <p>On 4/22/2025 at 8:22 a.m., during an observation, observed LVN 1 administer the crushed medications all at once via Resident 25's g-tube.</p> <p>On 4/22/2025 at 8:50 a.m., during an interview, LVN 1 confirmed that she mixed the eight medications together in one cup and administered them all at once.</p> <p>On 4/22/2025 at 1:49 p.m., during an interview, LVN 1 stated the facility's policy was to administer each crushed medication separately and flush with water between each medication. LVN 1 stated she did not do that. LVN 1 stated she put all the crushed medications together in one cup and administered them all together. LVN 1 stated it was important to administer each medication separately because, otherwise, there may be drug-to-drug interaction, which may render the medications less effective. LVN 1 stated it was also important to flush with water after giving each medication to ensure that the g-tube does not get clogged.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 4/24/2025 at 8:27 a.m., during an interview, the Director of Nursing (DON) stated it was the facility's policy to crush and administer medications separately when given through a g-tube in order to ensure that each medication is given in its entirety. The DON stated that, if mixed together, there is a potential for medications to interact with each other and render them less effective. The DON also stated it was important to make sure to flush with water after administering each medication to ensure that the g-tube does not get clogged. When asked if she considered what LVN 1 did to be a medication error, the DON stated that LVN 1 did not administer the medications correctly.</p> <p>During a review of the facility's policy and procedure titled, Adverse Consequences and Medication Errors, last reviewed on 10/30/2025, the policy and procedure indicated that a medication error is defined as the preparation or administration of drugs or biologicals which is not in accordance with the physician's orders, manufacturer's specifications, or accepted professional standards and principles of the professional providing services.</p> <p>During a review of the facility's policy and procedure titled, Administering Medications, last reviewed on 10/30/2025, the policy and procedure indicated that medications are administered in accordance with prescriber orders.</p>

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NAME OF PROVIDER OR SUPPLIER  Oakpark Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  9166 Tujunga Canyon Blvd Tujunga, CA 91042	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>47883</p> <p>Based on observation, interview, and record review, the facility failed to store food in accordance with professional standards for food service safety by not labeling:</p> <ul style="list-style-type: none"> <li>a. two boxes (24 count) of ice cream open on 4/17/2025 with use by date and expiration date.</li> <li>b. one gallon of sweet relish with use by date</li> <li>c. one gallon of creamy Italian Dressing with use by date</li> <li>d. one gallon of whole egg mayonnaise with use by date</li> <li>e. 1 pound of unsalted margarine with use by date and expiration date.</li> </ul> <p>These deficient practices had the potential for 45 out of 46 residents in the facility to be at risk for food borne illness (illness caused by food contamination with bacteria, viruses, parasites, or toxins).</p> <p>Findings:</p> <p>During a concurrent observation and interview on 4/21/25 at 8:00 a.m., with the Dietary Supervisor (DS) observed in the freezer two boxes (24 count) of ice cream opened on 4/17/2025 without a use by date and expiration date label.</p> <p>During a concurrent observation and interview on 4/21/25 at 8:05 a.m., with the Dietary Supervisor (DS), observed in the walk-in refrigerator one gallon of sweet relish without a use by date label, one gallon of creamy Italian dressing without a use by date label, one gallon of whole egg mayonnaise without a use by date label, and one ( 1 ) pound of unsalted margarine without a use by date label and expiration date. The DS stated there should have been a label with a use by date and expiration date for the food items and if there was not, that could affect the residents, and the residents could get sick.</p> <p>During an interview on 4/24/25 at 11 a.m., with the Director of Nursing (DON), the DON stated the food items should have been labeled with use by date and expiration date. The DON stated if the food was not labeled, the food could go bad, and the facility would want to prevent that.</p> <p>During a review of facility's policy and procedure (P&amp;P) titled, Procedure for freezer storage, last reviewed on 10/2024, the policy indicated that all frozen food should be labeled and dated.</p> <p>During a review of facility's policy and procedure (P&amp;P) titled, labeling and dating of foods, last reviewed on 10/2024 , the policy indicated: Newly opened food items will need to be closed and labeled with open date and use by date that follow the various storage guidelines .</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>47883</p> <p>Based on observation, interview and record review, the facility failed to:</p> <p>1. Ensure Certified Nursing Assistant (CNA 3) was wearing an isolation gown (type of personal protective equipment [PPE- specialized clothing or equipment worn by an employee for protection against infectious materials] used in healthcare settings to protect healthcare personnel from the spread of infection or illness, particularly from contact with blood and body fluids) while dressing a resident in the resident's room for one of five sampled residents (Resident 36) who were on enhanced barrier precautions (EBP -a set of infection control practices that use PPE to reduce exposure to reduce the spread of multidrug-resistant organisms [MDROs -microorganisms that are resistant to multiple classes of antibiotics and antifungals] in nursing homes).</p> <p>This deficient practice had the potential for transmission of bacteria that can lead to infection to other residents in the facility.</p> <p>2. Ensure Licensed Vocational Nurse 1 (LVN 1) donned a gown before administering medications via a gastrostomy tube (g-tube - a thin tube surgically inserted through the abdominal wall into the stomach) for a resident on enhanced barrier precautions (EBP - an infection control strategy that uses targeted gown and glove use during high-contact resident care activities to reduce the spread of multidrug-resistant organisms [MDROs - a germ that is resistant to many antibiotics]) for one (Resident 25) out of seven sampled residents investigated under the care area of infection control.</p> <p>This deficient practice had the potential to place the resident at increased risk of developing an infection.</p> <p>Findings:</p> <p>1. During a review of Resident 36's Admission Record, the Admission Record indicated the facility admitted the resident on 6/3/2022 and readmitted the resident on 3/22/2023 with diagnoses that included chronic obstructive pulmonary disease (a lung diseases that block airflow and make it difficult to breathe), urinary tract infection (UTI- an infection in any part of the urinary system), and atrial fibrillation (a heart condition that causes an irregular and often abnormally fast heart rate).</p> <p>During a review of Resident 36's Minimum Data Set (MDS - a resident assessment tool) dated 3/25/2025, the MDS indicated the resident had a moderately impaired cognition (mental abilities, including remembering things, making decisions, concentrating, or learning) and required substantial assistance from staff for toileting hygiene, shower, dressing and personal hygiene.</p> <p>During a review of Resident 36's Urine Culture Result (a lab test that examines a urine sample to see if there are any bacteria) dated 3/24/2025, the Urine Culture Result indicated Resident 36 was positive for extended spectrum beta-lactamase (ESBL- enzymes [proteins that help speed up metabolism] produced by bacteria that make them resistant to antibiotic) producing Escherichia coli (E. coli- type of bacteria that can cause food-borne illness [food poisoning]).</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 36's Surveillance Data Collection Form (a systematic collection of data to track infection which is collected when a resident has certain signs and symptoms that could be a bacterial infection) dated 3/24/2025, the Surveillance Data Collection Form indicated Resident 36's urinalysis (UA - urine test to examine the physical, chemical, and microscopic examination of urine) was positive for ESBL and Resident 36 was on antibiotic (a medication that fights bacterial infection) therapy and contact precautions (a measure taken to prevent the spread of germs through direct or indirect contact with person or their environment) per protocol.</p> <p>During a concurrent observation and interview on 4/21/2025 at 10 a.m., with</p> <p>CNA 3, observed Resident 36's room with signage that indicated Resident 36 was on EBP. Observed CNA 3 dressing Resident 36's in his bed without wearing an isolation gown. When asked why CNA 3 was not wearing the isolation gown when providing care for Resident 36, CNA 3 stated that she was not aware that Resident 36 was on EBP precaution and that she needed to wear an isolation gown when providing care for him.</p> <p>During a concurrent interview and record review on 4/23/2025 at 11:14 a.m., with the Infection Preventionist (IP), reviewed Resident 36's nursing progress note dated 4/1/2025. The IP stated Resident 36's nursing progress note dated 4/1/2025, indicated that contact isolation was discontinued on 4/1/2025 and Resident 36 was placed on EBP. The IP stated that CNA 3 should wear an isolation gown while dressing Resident 36 to prevent the spread of infection.</p> <p>During an interview on 4/24/2025 at 11 a.m., with the Director of Nursing</p> <p>(DON), the DON stated that CNA 3 should have worn an isolation gown while dressing Resident 36 who was on EBP. The DON stated that this deficient practice placed other residents in the facility at risk of transmission of bacteria that can lead to infection.</p> <p>During a review of the facility's policy and procedure titled, Enhanced Barrier</p> <p>Precautions, last reviewed on 10/2024, the policy and procedure indicated, Enhanced Barrier Precautions are utilized to prevent the spread of multi-</p> <p>drug-resistant organisms (MDRO) to residents .EBPS employ targeted gowning</p> <p>and glove use during high contact resident care activities .Example of high-</p> <p>contact resident care activities requiring the use of gown and gloves for EBP</p> <p>include a. dressing .EBP are indicated (when contact precautions do not</p> <p>otherwise apply) for residents infected or colonized (microorganism is present on or in a host, growing and multiplying without causing any signs or symptoms of infection or disease) with the following: ESBL-producing Enterobacterales.</p> <p>38549</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. During a review of Resident 25's Admission Record, the Admission Record indicated the facility originally admitted the resident on 3/28/2024 and readmitted the resident on 12/3/2024 with diagnoses including Parkinsonism (a term used to describe a group of movement disorders that share similar symptoms to Parkinson's disease [a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements]), gastrostomy status (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), a history of urinary tract infections (UTI - an infection in the bladder/urinary tract), and a history of other infectious and parasitic diseases.</p> <p>During a review of Resident 25's Minimum Data Set (MDS - a resident assessment tool), dated 4/1/2025, the MDS indicated the resident had severely impaired cognitive (thought processes) skills for daily decision making and maximal assistance from staff for most activities of daily living (ADLs - activities such as bathing, dressing, and toileting a person performs daily).</p> <p>During a review of Resident 25's physician's order, dated 4/8/2025, the order indicated that enhanced barrier precautions should be observed at all times while providing high-contact care activities every shift for a history of MDRO.</p> <p>On 4/22/2025 at 8:17 a.m., during med pass observation, observed LVN 1 administer medications to Resident 25 via g-tube. LVN 1 was not wearing a gown.</p> <p>On 4/22/2025 at 8:50 a.m., during an interview, LVN 1 confirmed that she was not wearing a gown when she administered medications to Resident 25 via g-tube.</p> <p>On 4/23/2025 at 2:02 p.m., during an interview, the Infection Preventionist (IP) stated that any resident who had a history of MDRO or had an indwelling device was placed on enhanced barrier precautions, which meant that staff performing high-contact resident care would need to wear appropriate personal protective equipment (PPE - clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments). The IP stated that LVN 1 should have worn a gown before administering medications via g-tube. The IP stated that the purpose of wearing PPE for high-contact activities was to limit and lower the possible risk of transmission of microorganisms among residents. The IP stated that, if PPE is not worn when indicated, then it increases the possible risk of infection and transmission of MDROs.</p> <p>During a review of the facility's policy and procedure titled, Enhanced Barrier Precautions, last reviewed on 10/30/2024, the policy and procedure indicated that enhanced barrier precautions are utilized to prevent the spread of multidrug resistant organisms to residents. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. Examples of high-contact care activities requiring the use of gown and gloves for EBPs include .device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc.). EBPs are indicated for residents with wounds and/or indwelling medical devices regardless of MDRO colonization.</p>		