STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055360	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakpark Healthcare Center	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)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure one (1) of five (5) sampled residents (Resident 24) was free from unnecessary (any medication in excessive dose, excessive duration, without adequate indication for its use and monitoring) use of psychotherapeutic drug (any medication capable of affecting the mind, emotions, and behavior) in accordance with facility policy and procedures by failing to ensure: 1.Resident 24 had specific target behaviors monitored related to the use of quetiapine (antipsychotic [a psychotherapeutic medication used to treat mental illness]), between 12/11/2025 and 4/8/2026. 2. Resident 24 did not have duplicate (more than one [1]) medication treatment with the use of quetiapine and Nuplazid (an antipsychotic used to treat mental illness,) between 12/11/2025 and 4/8/2026. These deficient practices had the potential to place Resident 24 at risk for significant adverse consequence (unwanted, uncomfortable, or dangerous effects that a drug may have) from the use of unnecessary psychotherapeutic drugs, which could result in impairment or decline in the residents' mental, physical condition, mental, functional, and psychosocial status. Findings: During a review of Resident 24's admission Record (a document containing demographic and diagnostic information,) dated 4/7/2026, the record indicated Resident 24 was originally admitted to the facility on [DATE] and re-admitted on [DATE] with diagnosis including Parkinsonism (a disorder that causes movement problems such as slowness, stiffness, tremors, and balance issues,) psychotic disorder, depression, anxiety, insomnia (difficulty sleeping.) During a review of the Minimum Data Set ([MDS - a comprehensive assessment and care screening tool]) dated 1/2/2026, the MDS indicated Resident 24 had Brief Interview for Mental Status (BIMS) score of 12 indicating moderately impaired cognition for daily decision making, had no symptoms of feeling down, depressed or hopeless, and was not marked for having trouble falling asleep, having hallucinations or delusions, and was taking antipsychotics on a routine basis. During a review of the History and Physical report completed on 3/25/2025, the report indicated Resident 24 sometimes had capacity to understand and make decisions. During a review of Resident 24's Order Summary Report dated 4/7/2026, the report indicated Resident 24 was prescribed: Nuplazid 34 milligram ([mg - a unit of measure of mass]) capsule orally once a day for Parkinson's induced psychosis manifested by verbalizing auditory and visual hallucinations that people are after her, starting 5/7/2025. Quetiapine 25 mg tablet orally in the afternoon for psychosis manifested by delusions and visual hallucinations, starting 12/11/2025. During a review of Resident 24's Medication Administration Record (MAR - a record of medications administered to residents), for April 2026, the MAR indicated Resident 24 was prescribed the following: Nuplazid 34 mg one (1) capsule orally once a day for Parkinson's induced psychosis manifested by verbalizing auditory and visual hallucinations that people are after her, to give at 9 a.m. Monitor with hashmark every shift for episodes of Parkinson's induced psychosis manifested by verbalizing auditory and visual hallucinations that people are after her for Nuplazid use. There were total of 10 episodes of psychosis manifested by verbalizing auditory and visual hallucinations that people are after her marked on the following days and shifts: four (4) total episodes for 7 a.m. to 3 p.m. shift on: 4/1, 4/2, 4/4, 4/5/2026 five (5) total episodes for 3 p.m. to 11 (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055360	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakpark Healthcare Center	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)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	p.m. shift on: 4/1, 4/2, 4/3, 4/4, 4/5/2026 one (1) total episode for 11 p.m. to 7 a.m. shift on: 4/4/2026 Quetiapine 25 mg one (1) tablet orally in the afternoon for psychosis manifested by delusions and visual hallucinations, to give at 2:30 p.m. Monitor with hashmark every shift for episodes of psychosis manifested by delusions and visual hallucinations for quetiapine use. There were total of 17 episodes of psychosis manifested by delusions and visual hallucinations on the following days and shifts: seven (7) total episodes for 7 a.m. to 3 p.m. shift on: 4/1, 4/2, 4/3, 4/4, 4/5, 4/6, 4/7/2026 six (6) total episodes for 3 p.m. to 11 p.m. shift on: 4/1, 4/2, 4/3, 4/4, 4/5, 4/6/2026 four (4) total episodes for 11 p.m. to 7 a.m. shift on: 4/3, 4/4, 4/5, 4/6/2026 During a concurrent record review and interview on 4/7/2026 at 2:35 p.m., with the Director of Nursing (DON,) the DON reviewed Resident 24's History and Physical, MDS dated [DATE], Order Summary dated 4/7/2026, MARs between January and April 2026. The DON stated psychotropic and antipsychotic medications should have specific indications and behaviors to ensure accurate behavior monitoring, assessment of medication effectiveness for specific behavior, and to prevent adverse consequences caused by not continuing unnecessary medications. The DON stated the addition of quetiapine order on 12/11/2025 did not have a specific behavior manifestation monitoring by not identifying the type of delusions and hallucinations, and duplicated Nuplazid's indication for psychosis manifested by visual hallucinations. The DON stated there are many different types of delusions and visual hallucinations, such as smelling smoke, seeing children and parents running around or at the window, and not having a specific behavior to monitor could result in varied, non-specific, subjective (based on the individual person's interpretation) and inaccurate behavior monitoring by licensed nurses. The DON stated, because of the duplication and non-specific behavior monitoring, the physician will not be able to make an accurate assessment for the effectiveness of quetiapine, potentially resulting in unnecessary dose increases. The DON stated the facility failed not to duplicate the indication of visual hallucinations and identify a specific behavior related to the use of quetiapine, placing Resident 24 at risk of experiencing additive medication adverse effects, such as such as drowsiness, dizziness, confusion, impaired coordination and respiratory depression, by receiving unnecessary psychotropic medications. During a review of facility Policy and Procedures (P&P,) titled Psychotropic Medication Use, last reviewed 10/29/2025, the P&P indicated: Residents will not receive medications that are not clinically indicated to treat a specific condition. 1.A psychotropic medication is any medication that affects brain activity associated with mental processes and behavior. 2. Drugs in the following categories are considered psychotropic medications and are subject to prescribing, monitoring, and review requirements specific to psychotropic medications: a. Anti-psychotics 3. Psychotropic medication management includes: d. adequate monitoring for efficacy. During a review of the facility's P&P titled Antipsychotic Medication Use, last reviewed 10/29/2025, the P&P indicated: Residents will not receive medications that are not clinically indicated to treat a specific condition. 1.Residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective. 2. The attending physician and other staff will gather and document information to clarify a resident's behavior. During a review of the facility's P&P titled Behavioral Assessment, Intervention and Monitoring, last reviewed 10/29/2025, the P&P indicated: 10. When medications are prescribed for behavioral symptoms, documentation will include: e. specific target behaviors. 4. If antipsychotic medications are used to treat behavioral symptoms, the IDT will monitor their indication.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055360	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakpark Healthcare Center	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)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan (a document outlining a detailed approach to care customized to an individual resident's need) for 3 out of 5 sampled residents (Residents 3, 15, and 40) when: a. Resident 3's care plan did not indicate the behavioral manifestations of the resident's anxiety. This deficient practice had the potential to result in Resident 3 not receiving the appropriate care and services for his diagnosis of anxiety. b. The injection site during administration of enoxaparin sodium solution (commonly known by the brand name Lovenox, a medication used to prevent and treat harmful blood clots) to Resident 15 was not documented as being rotated.This deficient practice had the potential to increase the risk of blood clots such as deep vein thrombosis (DVT-a serious condition where a blood clot forms in a deep vein, usually in the legs, causing pain, swelling, warmth, and redness) to Resident 15. c. Resident 40, who has a new diagnosis of epilepsy (chronic neurological condition characterized by recurrent, unprovoked seizures [a sudden, uncontrolled electrical disturbance in the brain, causing changes in behavior, consciousness, movements, or feelings]), did not have an individualized care plan with specific interventions to address epilepsy.This deficient practice had the potential to result in inadequate monitoring and management of seizures, placing Resident 15 at risk for injury or complications. Findings: a. During a review of Resident 3's admission Record, the admission Record indicated the facility originally admitted the resident on 11/5/2024 and most recently readmitted the resident on 12/22/2025 with diagnoses including, but not limited to, encephalopathy (damage or disease that affects the brain) and anxiety disorder (a mental health condition that causes excessive fear, worry, and feelings of dread and uneasiness). During a review of Resident 3's Minimum Data Set (MDS- a standardized assessment and care-screening tool), dated 2/12/2026, the MDS indicated the resident was able to express ideas and wants and was able to understand others. The MDS indicated Resident 3 required substantial assistance (helper does more than half of the effort) or moderate assistance (helper does less than half of the effort) for most activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a concurrent interview and record review on 4/9/2026 at 11:30 a.m. with the Director of Nursing (DON), Resident 3's care plan titled, Anxiety, dated 12/22/2025, did not indicate how the resident's anxiety manifested. The DON stated the care plan should be accurate and individualized. The DON stated the care plan needs to include the specific manifestations of anxiety because they are monitoring the resident's anxiety and assessing the effectiveness of the resident's anxiety medication. During a review of the facility's policy and procedure (P&P) titled Care Plans, Comprehensive Person-Centered, last reviewed on 10/29/2025, the P&P indicated a comprehensive, person-centered care plan that includes objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. The P&P indicated care plan interventions are derived from a thorough analysis gathered as part of the comprehensive assessment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055360	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakpark Healthcare Center	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)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. During a review of Residentˆ15's admission Record, the admission Record indicatedˆthe facility admitted Residentˆ15ˆto the facility onˆ9/16/2021ˆand readmitted on [DATE] with diagnoses includingˆdysphagiaˆ(difficulty swallowing), type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar),ˆandˆhypertensionˆ(a chronic high blood pressure).ˆˆ During a review of Resident 15's Health and Physical (H&P) datedˆ1/31/2026, the H&PˆindicatedˆResidentˆ15ˆdoes not have capacity to understand and make decisions.ˆˆ During a review of Residentˆ15's Minimum Data Set (MDS – a resident assessment tool), dated 2/19/2026, the MDS indicated Residentˆ15ˆhad moderate cognitive (ability to make decisions, understand, learn) impairment During a review of Residentˆ15's Physician Order Report dated 4/7/2026, the Physician Order Report indicated an order dated 10/6/2026, with a start date of 10/7/2024 for enoxaparin sodiumˆsolutionˆ40 milligrams (mg-unit of measurement)/0.4 milliliters (ml-unit of volume), one dose to be injected subcutaneouslyˆ(administered into the fatty tissue layer between the skin and muscle, often in the abdomen or upper arm)ˆone timeˆa dayˆforˆDVT and to rotateˆsites.ˆ During a review of Resident 15's Care Plan (CP) titled Skin discoloration in abdomen related to insulin and Lovenox injection, initiated 5/19/2025, the CP indicated a goal that Resident 15 will have no skin discoloration with re-evaluation date of 5/2026. The care plan indicated an intervention to rotate injection site regularly. During a review of Resident 15's Medication Administration Record (MAR) from 3/01/2026 to 4/08/2026, the MAR indicated that the box designated for documenting the injection site for enoxaparin sodium solution 40 mg/0.4 mL indicated 40 or 40 mg on the following dates: 3/1/2026 3/2/2026 3/3/2026 3/6/2026 3/7/2026 3/12/2026 3/14/2026 3/15/2026 3/16/2026 3/18/2026 3/19/2026 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055360	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakpark Healthcare Center	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)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3/20/2026 3/21/2026 3/22/2026 3/23/2026 3/24/2026 3/25/2026 3/26/2026 3/27/2026 3/28/2026 3/29/2026 3/30/2026 3/31/2026 4/01/2026 4/02/2026 4/04/2026 4/05/2026 4/06/2026 During a concurrent interview and record review on 4/7/2026 at 4:06 p.m. with the Director of Nursing (DON), Resident 15's care plan, physician orders, progress notes and MAR from 3/01/2026 to 4/07/2026 were reviewed. The DON stated that licensed nurses are required to document the correct injection site in the MAR for all subcutaneous medications. The DON stated that licensed nurses have been documenting 40 in the injection site field on multiple dates in March 2026 and April 2026, which is not an anatomical site and as a result the resident's care plan intervention to rotate injection site was not followed. The DON stated that failure to rotate Lovenox injection sites could result in pain, nodules, and poor absorption. The DON stated that it is important for licensed nurses to document the actual injection site so the DON can verify where the last dose was administered. The DON stated she could not provide any documentation showing that licensed nurses rotated the Lovenox injection sites. During a review of the facility's policy and procedure (P&P) titled Care Plans, Comprehensive Person-Centered revised on 10/29/2025, the P&P indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055360	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakpark Healthcare Center	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)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and functional needs is developed and implemented for each resident. c. During a review of Resident 40's admission Record, the admission Record indicated the facility admitted Resident 40 to the facility on 2/21/2026 and readmitted Resident 40 on 4/02/2026 with diagnoses that included epilepsy (chronic neurological condition characterized by recurrent, unprovoked seizures (a sudden, uncontrolled electrical disturbance in the brain, causing changes in behavior, consciousness, movements, or feelings), type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar), and hypertension (a chronic high blood pressure). During a review of Health and Physical (H&P) dated 4/6/2026, the H&P indicated Resident 40 has a diagnosis of seizure (a sudden, uncontrolled electrical disturbance in the brain, causing changes in behavior, consciousness, movements, or feelings). During a review of Resident 40's Minimum Data Set (MDS – a resident assessment tool), dated 2/25/2026, the MDS indicated Resident 40 had moderate to severe cognitive (ability to make decisions, understand, learn) impairment. The MDS indicated Resident 40 required partial to moderate assist (helper does less than half of the effort) with rolling left and right, sit to lying, lying to sitting on side of the bed. The MDS indicated that Resident 40 required substantial/maximal assistance (helper does more than the effort) with sit to stand, chair toilet transfer and toilet transfer. During a review of Resident 40's Physician Order Report dated 4/9/2026, the Physician Order Report indicated an order dated 4/2/2026, with the start date of 4/3/2026 to give Levetiracetam (anti-seizure medication) oral (by mouth) tablet 250 milligrams (mg -unit of measurement) two times a day for seizure disorder. During a review of Resident 40's Medication Administration Record (MAR) dated 4/01/2026 to 4/30/2026, the MAR indicated Resident 40 received Levetiracetam two times a day for seizure disorder from 4/3/2026 to 4/8/2026. During a review of Resident 40's Licensed Progress Note dated 3/28/2026 timed at 7:25 P.M., the Licensed Progress Note indicated on 3/28/2026 at 7:25 P.M., Resident 40 was in bed while experiencing a seizure. Resident 40 was transferred to the hospital via 911. During a review of Resident 40's care plan titled At Risk for injuries related to seizure disorder, initiated 4/2/2026, the CP indicated a goal that Resident 40 will show no sign and symptoms of seizure tremors daily. The CP indicated the following interventions: administer medication as ordered by physician, assess for auras(a small, localized disturbance in the brain—that often acts as a warning sign before a seizure) that may indicate and impending seizure, record characteristic of seizure such as duration, onset, body movement , notify physician if experiencing seizure, lab as ordered , Levetiracetam 250 mg tablet by mouth two times a day . During an observation and interview on 4/8/2026 at 1:34 p.m., with the Director of Nursing (DON) in Resident 40's s room, Resident 40's metal side rail observed with no padding. The DON stated Resident 40 had a seizure and was transferred to hospital due to seizure recently. The DON stated Resident 40's side rails must be padded to prevent potential injury during seizure. During concurrent interview and record review on 4/8/2026 at 1:37 p.m., with the DON, Resident 40's care plan titled At Risk for injuries related to seizure disorder, initiated 4/2/2026 was reviewed. The DON stated that Resident 40's CP is not resident specific. The DON stated the CP was missing (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055360	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakpark Healthcare Center	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)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interventions such as padding the side rails to prevent injury, monitoring and documenting seizures and medication side effects. During an interview on 4/9/2026 at 9:23 a.m., with the Minimum Data Set (MDS) nurse, the MDS nurse stated that Resident 40 has a seizure diagnosis, and for a resident with a seizure diagnosis, the side rails must be padded to prevent potential injury. The MDS nurse further stated that staff must monitor and document each shift whether the resident is experiencing seizures, as well as any side effects or adverse reactions to the medication. The MDS nurse further stated that these interventions should have been included in the care plan, as the care plan serves as a guideline for staff to ensure they know what to focus on in providing appropriate care. During a review of the facility's policy and procedure (P&P) titled Care Plans, Comprehensive Person-Centered revised on 10/29/2025, the P&P indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change. The interdisciplinary team reviews and updates the care plan: when there has been a significant change in the resident's condition and when the resident has been readmitted to the facility from a hospital stay. During a review of the facility's P&P titled Seizures and Epilepsy - Clinical Protocol, revised on 10/29/2025, the P&P indicated the staff, and physician will monitor the progress of individuals with a new seizure or a seizure disorder and will modify interventions accordingly. They should document periodically and objectively the presence or absence of seizure activity. The staff and physician will monitor for complications related to antiepileptic medications; for example, dizziness, ataxia, somnolence, headache, diplopia, blurred vision, nausea, vomiting, and rash.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055360	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakpark Healthcare Center	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)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based onˆobservation,ˆinterview,ˆand record review the facilityˆfailed to:ˆ 1.Reconcileˆ(the process of comparing transactions and activity to supporting documentation)ˆoneˆ(1)ˆmedicationˆemergency kit(s)ˆ([eKITˆ- kit containing medications needed to be used during emergencies])ˆcontainingˆ([CS -ˆmedications which have a potential for abuse and may also lead to physical or psychological dependence, also known as narcotics orˆControlled Medication [CM])ˆforˆAprilˆ2026,ˆinˆoneˆ(1) ofˆoneˆ(1) inspectedˆmedicationˆroomsˆ(MedicationˆRoomˆ1.)ˆˆ 2. Reconcileˆthree (3) medicationˆeKITsˆcontainingˆCSsˆfor April 2026,ˆinˆone (1) of two (2) inspectedˆmedicationˆcarts (Medication Cartˆ South.)ˆˆˆ 3. Account forˆtwoˆ(2) dosesˆof CSˆfor Residentˆ46ˆinˆone (1) of two (2)ˆinspectedˆmedication carts (Medication Cartˆ South.)ˆˆ As a result, control and accountability of CSs did not follow state and federal regulations and facility policy and procedures.ˆˆˆ These deficient practices increased the opportunity for CSˆdiversionˆ(the transfer of a controlled medication or other medication from a lawful to an unlawful channel of distributionˆor use,)ˆandˆexposureˆofˆharmful medicationsˆtoˆresidents in the facility,ˆthatˆResidentˆ46ˆcould haveˆaccidental overdoseˆ(administration ofˆmore than the prescribed dose)ˆor underdose (less than the prescribed dose)ˆto CSˆpossibly leading to physical and psychosocial harm,ˆhospitalizationˆand deathˆandˆtheˆpotential to result in Residentˆ46'sˆˆhealth and well-being to be negatively impacted. 4. ˆAdminister enoxaparin sodiumˆsolutionˆ(commonly known by the brand name Lovenox, a medication used to prevent and treat harmful blood clots)ˆas ordered by the physicianˆfor one of two sampled residents (Resident 15) reviewed under the hospitalization care area.This failure had the potential to increase the risk of blood clots, such as deep vein thrombosis (DVT-a serious condition where a blood clot forms in a deep vein, usually in the legs, causing pain, swelling, warmth, and redness) to Resident 15. ˆ Findings:ˆ During an observation on 4/6/2026 at 12:38 p.m., with the Director of Nursing (DON,) in Medication Roomˆ1, there was:ˆ 1.One (1) medicationˆeKITˆcontainingˆCSs stored in the refrigerator and labeled Ativanˆ eKIT, without a CSˆaccountability log for the reconciliation of CS inventory count at every shift change for April 2026.ˆˆˆ During a concurrent interview,ˆthe DON acknowledged theˆeKITˆlabeledˆAtivanˆeKIT did not have an accountability log and was not reconciled at every shift in April 2026.ˆˆThe DONˆstatedˆthat all CSs, including medicationˆeKITsˆcontainingˆCSs should be reconciled and counted at every shift and documented on a CSˆaccountability log.ˆˆThe DONˆstatedˆit was important to account for all CSs to ensure accountability and prevent CS diversion. ˆThe DONˆstatedˆthat the facility willˆimmediatelyˆimplement an accountability log for reconciliation ofˆeKitsˆcontainingˆCSs.ˆ During an observation onˆ4/6/2026 atˆ12:46ˆp.m., with Licensed Vocational Nurse (LVN)ˆ4, in Medication Cartˆ South, there was a discrepancy in the count between the Medication Count Sheet accountability log and the amount of medication remaining in the medication cart or medication bubble pack (medication packaging system that contains individual doses of medication per bubble)ˆfor the following residents:ˆˆˆ 1.Oneˆ(1) dose ofˆmodafinilˆ(a CSˆusedˆforˆappetite stimulation)ˆ100ˆmilligram ([mg] – a unit of measure of mass) tablet wasˆextraˆinˆthe bubble pack compared to the countˆindicatedˆon (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055360	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakpark Healthcare Center	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)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	theˆMedication Count Sheet accountability log for Residentˆ46.ˆˆTheˆMedication Count Sheet accountability logˆforˆmodafinilˆindicated the bubble pack should have containedˆzero (0)ˆmodafinilˆ100ˆmg tablets,ˆafter the last administration ofˆmodafinilˆ100ˆmg tablet documented/signed-offˆonˆ4/6/2026 atˆ9ˆa.m., however the medication bubble pack containedˆone (1)ˆmodafinilˆ100ˆmg tablet and contained no other documentation.ˆ 2. One (1) dose ofˆlacosamideˆ(a CSˆused forˆseizureˆ[bursts of uncontrolled electrical activity between brain cells that causes temporary abnormalities in muscle movements, behaviors, sensations or states of awareness])ˆ50ˆmgˆtablet was extra in the bubble pack compared to the count indicated on theˆMedication Count Sheet accountability log for Resident 46.ˆˆTheˆMedication Count Sheet accountability logˆforˆlacosamideˆindicated the bubbleˆpack should have containedˆ18ˆlacosamideˆ50 mg tablets, after the last administration ofˆlacosamide 50 mg tablet documented/signed-offˆon 4/6/2026 at 9 a.m., however the medication bubble pack containedˆ19ˆlacosamideˆ50 mg tablet and contained no other documentation.ˆ During a concurrent observation in Medication Cart South, there were three (3)ˆmedicationˆeKITsˆstored at room temperature and labeled NM726, NARC1 118, and NARC2 185,ˆcontainingˆCSs without an accountability log for the reconciliation of CS inventory at every shift change for April 2026.ˆ During a concurrent interview, LVNˆ4ˆstated LVNˆ4ˆoverlooked to prepare and administerˆoneˆ(1)ˆmodafinilˆ100ˆmg tabletˆand one (1) lacosamide 50 mg tabletˆto Residentˆ46ˆatˆ9ˆa.m.ˆthat morning (4/6/2026),ˆbutˆdocumented/signed-offˆtheˆMedication Count Sheet accountability logˆbefore the medications wereˆadministered.ˆ LVNˆ4ˆstated LVNˆ4ˆfailed to follow the facility's policy of signingˆoffˆeach CM dose on theˆMedication Count Sheet accountability logˆafter preparingˆand administeringˆthe dose for the resident.ˆˆLVNˆ4ˆstated LVNˆ4ˆunderstood it was important to sign each dose once administered to ensure accountability, prevention of CSˆdiversion, and accidental exposures of harmful substances to residents. LVNˆ4ˆstated if documentationˆwasˆnotˆaccurateˆthen it can lead to medication error, such asˆunderdosingˆwhich couldˆincreaseˆthe risk of seizures, resulting inˆhospitalization andˆpossibly deathˆfor Resident 46.ˆˆLVN 4 stated that LVN 4ˆwillˆcommunicate withˆResident 46'sˆphysicianˆthat modafinil and lacosamide wereˆnot administeredˆat 9 a.m.ˆand obtainˆadditionalˆordersˆas necessary.ˆˆ Duringˆthe sameˆinterview,ˆLVNˆ4ˆstated that all CSs, including medicationˆeKITsˆcontainingˆCSsˆshould be reconciled at every shift.ˆˆLVNˆ4ˆstatedˆtheˆeKITsˆlabeledˆNM726, NARC1 118, and NARC2 185,ˆcontainingˆCSs in Medicationˆ Cart Southˆwereˆnot reconciled at every shift inˆAprilˆ2026, and it was important to account for all CSsˆto ensure accountability and prevent CS diversion.ˆˆˆ Duringˆan interview onˆ4/8/2026 atˆ11:20ˆp.m., with the DON,ˆthe DONˆstatedˆthat LVNˆ4ˆfailed to follow facility policy of documenting the preparation of CSˆon the Medication Count Sheet accountability log for Residentˆ46 after the preparation and administration of modafinil and lacosamide.ˆˆThe DONˆstatedˆnot documenting theˆMedication Count Sheetˆaccurately ˆcan lead to accountability failures, CSˆdiversion, inaccurate clinical records, accidental use,ˆpossibleˆoverdoseˆand underdoseˆof harmful substances for residents.ˆˆThe DONˆstatedˆthis failure increased the risk of Resident 46ˆexperiencing decreased appetite and potential seizures.ˆˆ During a review of Residentˆ46's admission Recordˆ(a document containing demographic and diagnostic information,)ˆdatedˆ4/7/2026, the admission Record indicated Residentˆ46ˆwas originally (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055360	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakpark Healthcare Center	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)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses including muscleˆwasting and epilepsy (a brain disorder characterized by recurring seizures). During a review of Resident 46'sˆOrder Summary Report, datedˆ4/7/2026, theˆreportˆindicatedˆResident 46 was prescribed:ˆ 1.modafinil 100 mg tablet orally in the morning for stimulant,ˆstartingˆ6/28/2025.ˆˆ 2. lacosamide 50 mg tablet orally twice a day for seizure,ˆstarting 6/27/2025.ˆ During a review of Resident 46'sˆMedication Administration Record ([MAR -ˆrecord of medications administered to a resident) forˆAprilˆ2026, the MARˆindicatedˆResident 46 was prescribed:ˆ 1.modafinil 100 mg tablet orally in the morning for stimulant, to be given at 9 a.m.ˆˆ 2. lacosamide 50 mgˆtabletˆorally twice a day for seizure, to be given at 9 a.m. and 5 p.m.ˆ During a review of the Policy and Procedures (P&P) titled Controlled Substances, last reviewed 10/29/2025, the P&P indicated: 8. CS are reconciled upon receipt, administration, disposition, and at the end pf each shift. 12. At the end of each shift: a. CMs are counted at the end of each shift. The nurse coming on duty and the nurse going off duty determine the count together. During a review of the P&P, titled Documentation of Medication Administration, last reviewed 10/29/2025, the P&P indicated: Administration of medication must be documented immediately after (never before) it is given. 4. During a review of Residentˆ15's admission Record, the admission Record indicatedˆthe facility admitted Residentˆ15ˆto the facility onˆ9/16/2021ˆand readmitted on [DATE] with diagnoses includingˆdysphagiaˆ(difficulty swallowing), type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar),ˆandˆhypertensionˆ(a chronic high blood pressure).ˆˆ During a review of Resident 15's Health and Physical (H&P) datedˆ1/31/2026, the H&PˆindicatedˆResidentˆ15ˆdoes not have capacity to understand and make decisions.ˆ During a review of Residentˆ15's Minimum Data Set (MDS – a resident assessment tool), dated 2/19/2026, the MDS indicated Residentˆ15ˆhad moderate cognitive (ability to make decisions, understand, learn) impairment.ˆThe MDS alsoˆindicated, Resident 15 was dependent (helper doesˆall ofˆtheˆeffort)ˆfor showering, requiredˆsubstantialˆmaximal assistˆ(helper does more thanˆhalf)ˆwithˆtoiletingˆhygiene, and required partial/moderate assist (helper does less than half)ˆwith eating,ˆupperˆand lower body dressing.ˆ During a review of Residentˆ15's Physician Order Report dated 4/7/2026, the Physician Order Report indicated an order dated 10/6/2026, with a start date of 10/7/2024 for enoxaparin sodiumˆsolutionˆ40 milligrams (mg-unit of measurement)/0.4 milliliters (ml-unit of volume), one dose (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055360	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakpark Healthcare Center	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)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to be injected subcutaneouslyˆ(administered into the fatty tissue layer between the skin and muscle, often in the abdomen or upper arm)ˆone timeˆa dayˆforˆDVT and to rotateˆsites.ˆ During a review of Resident 15's Medication Administration Record (MAR) dated 3/1/2026 to 3/31/2026, the MAR indicated that the box designated for documenting the administration of enoxaparin sodium solution 40 mg/0.4 ml subcutaneously once daily was marked with 9. The MAR indicated that 9 is a chart code for Other/See Progress Notes. During a review of Resident 15's Administration Note dated 3/13/2026 at 4:49 p.m., documented by LVN 2, the noteˆindicatedˆResident 15 did not receive the medication and it needed to be reordered. Duringˆanˆinterview on 4/7/2026 atˆ4:06ˆp.m., with the Director of Nursing (DON),ˆthe DONˆstatedˆResident 15 did not receiveˆthe Lovenoxˆinjection as ordered by physicianˆon 3/13/2026.ˆThe DONˆstatedˆthat Resident 15 isˆnon- ambulatory, and the potential outcome of not receivingˆLovenoxˆas ordered could include the development of DVT and/or a heartˆattack (occurs when blood flow to the heart is blocked, causing muscle tissue to die). The DON explained that if a medication is not available on the unit, nursing staff are expected to check the emergency kit (EKit-a supply of medications kept at the facility for immediate use in urgent situations, before a pharmacy can deliver the resident's prescribed medication) and obtain the medication from there or request a STAT (immediately or now) delivery from the pharmacy. The DONˆstatedˆthatˆLovenoxˆ40 mg was available in the EKit onˆ3/13/2026,ˆand LVN 1 should have obtained the medication from the EKit to administer it as ordered.ˆ Duringˆanˆinterview on 4/7/2026 atˆ4:34ˆp.m., withˆLVN 2,ˆLVN 2ˆstatedˆthat Residentˆ15ˆis non-ambulatory andˆphysician ordered theˆLovenoxˆinjection for DVTˆprophylaxis.ˆLVN 2ˆstatedˆshe was the nurse assigned to Resident 15 on 3/13/2026ˆfrom 3 p.m. to 11 p.m.ˆLVN 2ˆstatedˆshe did not administerˆLovenoxˆbecause the medication was not available at the time of the scheduled dose.ˆ LVN 2ˆstatedˆshe did not check the EKit to verify whether the medication was available and did not request the medication to be sent STAT from the pharmacy. ˆLVN 2ˆfurtherˆstatedˆthat the potential outcome of Resident 15 not receivingˆ Lovenoxˆas ordered include blood clot formation, DVT, and other related complications.ˆ Duringˆaˆreview of the facility's policy and procedureˆ(P&P)ˆtitledˆMedicationˆadministrationˆreviewedˆonˆ10/29/2025, the P&Pˆindicatedˆmedicationsˆare administered in a safe andˆtimelyˆmanner, and as prescribed.ˆMedications are administered in accordance with prescriber orders, including any required time frame. Medications are administered within one (I) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). If a dosage is believed to be inappropriate or excessive for a resident. or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication will contact the prescriber, the residents attending physician or the facility's medical director to discuss the concerns. Duringˆaˆreview of the facility's policy and procedureˆ(P&P)ˆtitledˆAdverse Consequences and Medication Errors,ˆreviewed onˆ10/29/2025, the P&Pˆindicatedˆexamples of medications errorsˆincludeˆomission - a drug is ordered but not administered. ˆ

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055360	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakpark Healthcare Center	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)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to: 1.Label one (1) Rocklatan (a medication used to treat glaucoma [a condition of increased pressure in the eyeball]) eye drop bottle (medication stored in a plastic container) for Resident 9, with an open date in accordance with facility requirements and manufacturer's requirements in one (1) of two (2) inspected medication carts (Medication Cart East.) 2. Label one (1) latanoprost (a medication used to treat glaucoma eye drop bottle for Resident 30, with an open date in accordance with facility requirements and manufacturer's requirements in one (1) of two (2) inspected medication carts (Medication Cart South.) 3. Store four (4) albuterol (a medication used for cough) inhalation solutions at room temperature in the foil pouch (package made of foil protecting the inhalation solution from light and degradation) for Resident 41, in accordance with the manufacturer's requirements in one (1) of two (2) inspected medication carts (Medication Station South.) 4. Store one (1) latanoprost eye drop bottle for Residents 45, in accordance with the manufacturer's requirements in one (1) of two (2) inspected medication carts (Medication Cart South). 5. Remove from use and discard 40 expired guaifenesin with dextromethorphan (medication used for cough) oral liquid cups from facility stock, in accordance with manufacturer's requirements and facility policy and procedures, in one (1) of one (1) inspected medication rooms (Medication room [ROOM NUMBER].) These deficient practices increased the risk that Residents 9, 30, 41, 45 and others in the facility could have received medication that had become ineffective or toxic due to improper storage or labeling, possibly resulting in harm and health complications, such as worsening glaucoma, unrelieved cough, leading to requiring alternate medical treatments and interventions. Findings: During an observation on 4/6/2026 at 12:38 p.m., in Medication room [ROOM NUMBER], with the Director of Nursing (DON,) the following medications were found either stored in a manner contrary to their respective manufacturer's requirements, expired and not discarded, or stored contrary to facility policies: 1.Four (4) unopened boxes containing ten (10) guaifenesin with dextromethorphan oral liquid cups for facility stock was found stored at room temperature in the cabinet with other unexpired facility stock medications and labeled with an expiration date of 2/2026. According to the manufacturer date imprinted on the guaifenesin with dextromethorphan cups, the medication should be used or discarded by February 2026. During a concurrent interview, the DON acknowledged 40 guaifenesin with dextromethorphan oral liquid cups for facility stock expired February 2026. The DON stated expired medications should be removed from use and placed in the expired medication bin to be disposed of and prevent accidental use. The DON stated the guaifenesin with dextromethorphan oral liquid cups needed to be removed from use before February 2026. The DON stated expired medications have lost potency (strength), are ineffective and may not work properly when used in error for residents in the facility. The DON stated several licensed nurses failed to remove expired medications from use and place in a designated area intended for disposal, increasing the potential for use of expired guaifenesin with dextromethorphan and not relieving resident's cough. During an observation on 4/6/2026 at 12:46 p.m., in Medication Cart South, with Licensed Vocational Nurse (LVN) 4 the following medications were found either stored in a manner contrary to their respective manufacturer's requirements, not labeled with an open date as required by their respective manufacturer's specifications, or stored and labeled contrary to facility policies: 1.One (1) open latanoprost eye drop bottle for Resident 30 was found stored at room temperature and not labeled with a date on which storage at room temperature began. According to the manufacturer's product storage and labeling, opened latanoprost bottles may be stored at room temperature up to 77 degrees Fahrenheit and used or discarded within 6 weeks of opening/use. 2. One (1) unopened latanoprost eye drop bottle for Resident 45 was found stored at room temperature (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055360	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakpark Healthcare Center	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)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and not labeled with a date on which storage at room temperature began, with an additional blue label by pharmacy indicating to refrigerate. According to the manufacturer's product labeling, unopened latanoprost bottles should be stored in the refrigerator between 36 and 46 degrees Fahrenheit (˚) and used or discarded within 6 weeks of opening or once they've been stored at room temperature. 3. One (1) open albuterol inhalation solution foil pouch for Resident 41, was found stored at room temperature and not labeled with a date indicating when the inhalation solutions were removed from the foil (aluminum) pouch (envelope.) Four (4) inhalation solutions were observed stored outside the foil pouch. According to the manufacturer's product storage and labeling, albuterol inhalation solutions should be stored between 68 and 77 degrees Fahrenheit, protected from light, and stored in the pouch until time of use. During a concurrent interview, LVN 4 stated that the latanoprost eye drop bottles were not stored properly for Resident 30 and 45. LVN 4 stated multi-dose (containing more than one dose) medications, such as eye drop bottles, need to have a label indicating date of first use to know when they expire and be disposed. LVN 4 stated unopened latanoprost eye drop bottles should be stored in the refrigerator, as indicated by the pharmacy label, and opened latanoprost eye drop bottle should be disposed six (6) weeks after first use. LVN 4 stated that LVN 4 was unaware when both latanoprost bottles were placed at room temperature, and therefore unaware when the six (6) week expiration date was. LVN 4 stated that improperly stored eye drops medications and those used beyond the expiration date have lost potency, maybe contaminated (impure, unclean,) and will not be effective in treating the resident's condition, in addition causing eye infections since the bottle was no longer sterile (free of bacteria.) LVN 4 stated when using these latanoprost eye drop bottles for Resident 30 and 45 accidentally beyond six (6) weeks can cause adverse effects, not effectively treat the glaucoma, cause infections, further nerve damage and potentially lead to blindness. LVN 4 stated the latanoprost bottles for Resident 30 and 45 needed to be immediately removed from the medication cart and replaced with a new one from pharmacy. During the same interview, LVN 4 stated four (4) albuterol inhalations for Resident 41 were stored outside the opened foil pouch. LVN 4 stated according to manufacturer guidelines the inhalation solutions needed protection from light and to remain in the foil pouch until time of use. LVN 4 stated four (4) albuterol inhalation solutions were considered expired and had lost potency due to improper storage and needed to be discarded to prevent administration of ineffective medication to Resident 41. LVN 4 stated administering ineffective albuterol to Resident 41 was not effective in treating the cough, potentially making the cough worse and requiring additional intervention. LVN 4 stated four (4) albuterol inhalation solutions for Resident 41 should be discarded from Medication Cart South. During an observation on 4/6/2026 at 1:42 p.m., in Medication Cart East, with LVN 3 the following medications were found either stored in a manner contrary to their respective manufacturer's requirements, not labeled with an open date as required by their respective manufacturer's specifications, or stored and labeled contrary to facility policies: -One (1) open and used Rocklatan eye drop bottle for Resident 9 was found stored at room temperature and not labeled with a date on which storage at room temperature began. According to the manufacturer's product storage and labeling, opened Rocklatan bottles may be stored at room temperature 36 to 77 degrees Fahrenheit and used or discarded within 6 weeks of opening/use. During a concurrent interview, LVN 3 stated that the Rocklatan eye drop bottle was a multi-dose medication, was open, used and not labeled with the date of first use. LVN 3 stated multi-dose medications need to have a label indicating date of first use to know when it expires and when to be disposed. LVN 3 stated according to the manufacturer guideline, Rocklatan eye drop bottle should be disposed six (6) weeks after first use to ensure the medication was still potent, and sterile. LVN 3 stated LVN 3 was unaware when the bottle was first used, and that the bottle was now considered expired. LVN 3 stated continued use of the Rocklatan eye drop bottle for Resident 9 was not effective in treating the resident's glaucoma and can harm the resident by causing eye infections and potential blindness. LVN 3 stated the Rocklatan eye drop bottle for Resident 9 needed to be removed from Medication Cart East and replaced with a new one from pharmacy. During an interview on 4/8/2026 at (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055360	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakpark Healthcare Center	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)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11:20 p.m., with the DON, the DON stated the latanoprost eye drop bottle for Resident 30 and Rocklatan for Resident 9 were not labeled with a date when first used, and the latanoprost for Resident 45 was not stored in the refrigerator. The DON stated eye drop bottles were considered multi-dose medications and opened bottles had six (6) week expiration dates to ensure the medications were potent, sterile and not contaminated. The DON stated these eye drop bottles were now considered expired, have potentially lost their efficacy due to improper storage and no longer considered sterile. The DON stated these failures could lead to the administration of expired and ineffective latanoprost to Resident 30 and 45, and Rocklatan to Resident 9 resulting in not effectively treating glaucoma, and leading to eye nerve damage, infections and possible blindness. The DON stated severed LVNs failed to store latanoprost for Resident 45 in the refrigerator and latanoprost for Resident 30 and failed to label Rocklatan for Resident 9 with a date indicating when use began. During the same interview, the DON stated that albuterol inhalation solutions should be stored in the foil pouch to protect from light and degradation (breakdown) of the medication. The DON stated improperly stored albuterol inhalation solutions have lost effectiveness and when administered in error will not treat the cough further causing respiratory (breathing) distress for Resident 9 requiring further interventions. During a review of the facility's policy and procedures (P&P), titled Administering Medications, last reviewed 10/29/2025, the P&P indicated 12. When opening a multi-dose container, the date opened is recorded on the container. During a review of the facility's P&P, titled Storage ofMedications, last reviewed 10/29/2025, the P&P indicated: 7. Medications requiring refrigeration are stored in the refrigerator. During a review of the facility's P&P, titled Drug Disposition - Procedure for Disposal, last reviewed 10/29/2025, the P&P indicated: Discontinued or outdated non-controlled drugs are to be stored in a secured area designated for that purpose until picked up by the pharmaceutical waste disposal service or the pharmacy personnel. During a review of manufacturer's guide Highlights of Prescribing Information for latanoprost dated January 2023, the guide indicated Protect from light. Store unopened bottle(s) under refrigeration at 36 to 46 F. Once a bottle is opened for use, it may be stored at room temperature up to 77 F for 6 weeks. Serious damage to the eye and subsequent loss of vision may result from using contaminated solutions. During a review of manufacturer's guide Highlights of Prescribing Information for Rocklatan dated January 2025, the guide indicated Protect from light. After opening, the product may be kept at 36 F to 77 F for up to 6 weeks. Serious damage to the eye and subsequent loss of vision may result from using contaminated solutions. During a review of manufacturer's guide Highlights of Prescribing Information for albuterol dated January 2021, the guide indicated Protect from light. Store in pouch until time of use. Store at 68 to 77 F.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055360	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakpark Healthcare Center	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)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and food preparation practices in the kitchen when: 1. The shelves in a refrigerator in the kitchen storage room were rusted. 2. A cook was wearing a bracelet while handling food. These failures had the potential to result in harmful bacterial growth that could lead to foodborne illness (a disease caused by consuming food or drinks that are contaminated by germs or chemicals) in 47 of 48 residents who received food from the kitchen. Findings: 1. During a concurrent observation and interview on 4/7/2026 at 10:41 a.m. with the Dietary Service Manager (DSM) in the dry storage room, the shelves in the refrigerator had rust with amber discoloration. The DSM stated the shelves should not be that way and that because of the rust they cannot effectively clean the shelves During a review of the facility's policy and procedure (P&P) titled, Sanitation, last reviewed on 10/29/2025, the P&P indicated the food service area will be maintained in a clean and sanitary manner. The P&P further indicated all shelves and equipment will be kept clean, maintained in good repair and be free from breaks, corrosion, cracks, and chipped areas that may affect their use or proper cleaning. 2. During a concurrent observation and interview on 4/7/2026 at 12:21 p.m. in the kitchen, [NAME] 1 was wearing a bracelet and had no gloves on while serving food from the stove to resident trays. The DSM observed and validated [NAME] 1 was wearing a bracelet, and said she was unsure of their policy on wearing bracelets while in the kitchen. During a concurrent interview and record review on 4/7/2026 at 3:40 p.m. with the DSM, the FDA Food Code, dated 2022, and the facility's P&P titled, Food Preparation and Service, last reviewed on 10/29/2025, were reviewed. The FDA Food Code indicated, 2-303.11 Prohibition. Except for a plain ring such as wedding band, while preparing food, food employees may not wear jewelry including medical information jewelry on their arms and hands. The P&P indicated, Jewelry is worn minimally and hand jewelry (i.e. wedding ring) is covered with gloves. The DSM stated they follow the food code and jewelry should not be worn for proper infection control for the residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055360	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakpark Healthcare Center	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)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to maintain accurate clinical records in accordance with accepted professional standards and practices for one of two residents (Resident 15) reviewed under the hospitalization care area by: 1. Failing to ensure licensed nurses accurately documented the injection site in the MAR during administration of enoxaparin sodiumˆsolution (commonly known by the brand name Lovenox, a medication used to prevent and treat harmful blood clot). 2. Failing to ensure licensed nurses accurately documented the injection site and blood sugar value in the MAR during administration of Insulin Glargine Solution (a long acting la-made insulin used to treat diabetes mellitus [DM-a disorder characterized by difficulty in blood sugar control and poor wound healing]). This deficient practice placed the resident at risk for not receiving the appropriate care due to inaccurate documentation of injection sites and amount of insulin administered to Resident 15, which may result in failure to rotate injection sites and lead to as lipodystrophy (abnormal distribution of fat) and cutaneous amyloidosis (is a condition in which clumps of abnormal proteins called amyloids build up in the skin) and complications related to ineffective management of Resident 15's blood sugar.Findings: During a review of Residentˆ15's admission Record, the admission Record indicatedˆthe facility admitted Residentˆ15ˆto the facility onˆ9/16/2021ˆand readmitted on [DATE] with diagnoses includingˆdysphagiaˆ(difficulty swallowing), type 2 diabetes mellitus (DM-a chronic condition that affects the way the body processes blood sugar),ˆandˆhypertensionˆ(a chronic high blood pressure).ˆˆ During a review of Resident 15's Health and Physical (H&P) datedˆ1/31/2026, the H&PˆindicatedˆResidentˆ15ˆdoes not have capacity to understand and make decisions.ˆˆ During a review of Residentˆ15's Minimum Data Set (MDS - a resident assessment tool), dated 2/19/2026, the MDS indicated Residentˆ15ˆhad moderate cognitive (ability to make decisions, understand, learn) impairment During a review of Residentˆ15's Physician Order Report dated 4/7/2026, the Physician Order Report indicated an order dated 10/6/2026, with a start date of 10/7/2024 for enoxaparin sodiumˆsolutionˆ40 milligrams (mg-unit of measurement)/0.4 milliliters (ml-unit of volume), one dose to be injected subcutaneouslyˆ(administered into the fatty tissue layer between the skin and muscle, often in the abdomen or upper arm)ˆone timeˆa dayˆforˆDVT and to rotateˆsites.ˆ During a review of Resident 15's Medication Administration Record (MAR) from 3/01/2026 to 4/08/2026, the MAR indicated that the box designated for documenting the injection site for enoxaparin sodium solution 40 mg/0.4 mL indicated 40 or 40 mg on the following dates: 3/1/2026 3/2/2026 3/3/2026 3/6/2026 3/7/2026 3/12/2026 3/14/2026 3/15/2026 3/16/2026 3/18/2026 3/19/2026 3/20/2026 3/21/2026 3/22/2026 3/23/2026 3/24/2026 3/25/2026 3/26/2026 3/27/2026 3/28/2026 3/29/2026 3/30/2026 3/31/2026 4/01/2026 4/02/2026 4/04/2026 4/05/2026 4/06/2026 During a review of Resident 15's Medication Administration Record (MAR) from 3/01/2026 to 3/31/2026, the MAR indicated an order for Insulin Glargine Solution Pen 100 units/milliliters (ml-unit of volume). Inject 10 units subcutaneously in the morning for DM. Hold if blood sugar (BS) is less than 100 milligrams (mg-unit of measurement)/deciliter (dl- unit of volume). The MAR indicated that on 3/2/2026, the injection site indicated an entry of NA, and the blood sugar was documented as 10. On 3/4/2026, the injection site indicated an entry of 10. During a concurrent interview and record review on 4/7/2026 at 4:06 p.m. with the Director of Nursing (DON), Resident 15's MAR from 3/01/2026 to 4/07/2026 were reviewed. The DON stated that licensed nurses are required to document the correct injection site in the MAR for all subcutaneous medications. The DON stated that licensed nurses have been documenting 40 in the injection site field on multiple dates in March 2026 and April 2026, which is not an anatomical site and does not meet documentation standards. The DON the documentation was incorrect and should not have occurred. During concurrent interview and record review on 4/7/2026 at 4:08 p.m. with the Director of Nursing (DON), Resident 15's MAR from 3/01/2026 to 4/07/2026 was reviewed. The DON (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055360	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakpark Healthcare Center	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)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated the blood sugar (BS) entry of 10 documented on 3/2/2026 was inaccurate, as this value is outside the expected physiological range. Additionally, on 3/4/2026, the licensed nurse documented 10 in the injection site field, which the DON acknowledged was not an acceptable or appropriate site entry. The DON stated that licensed nurses must accurately document injection sites and clinical values to prevent confusion and ensure proper monitoring of residents' condition. Duringˆaˆreview of the facility's policy and procedureˆ(P&P)ˆtitled Charting and Documentation,ˆrevised onˆ10/29/2025, the P&P indicated documentation in the medical record, will be objective (not opinionated or speculative), complete, and accurate. As required or indicated for medication. the individual administering the medication records in the resident's medical record: the injection site (if applicable).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055360	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakpark Healthcare Center	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to: 1.Label one (1) Rocklatan (a medication used to treat glaucoma [a condition of increased pressure in the eyeball]) eye drop bottle (medication stored in a plastic container) for Resident 9, with an open date in accordance with facility requirements and manufacturer's requirements in one (1) of two (2) inspected medication carts (Medication Cart East.) 2.Label one (1) latanoprost eye drop bottle for Resident 30, with an open date in accordance with facility requirements and manufacturer's requirements in one (1) of two (2) inspected medication carts (Medication Cart South.) 3. Store one (1) latanoprost eye drop bottle for Residents 45, in accordance with the manufacturer's requirements in one (1) of two (2) inspected medication carts (Medication Cart South). These deficient practices increased the risk that Residents 9, 30, and 45 could receive contaminated eye drop medications leading to health complications such as worsening glaucoma, eye infections and possible blindness. Findings: During an observation on [DATE] at 12:46 p.m., in Medication Cart South, with Licensed Vocational Nurse (LVN) 4 the following medications were found either stored in a manner contrary to their respective manufacturer's requirements, not labeled with an open date as required by their respective manufacturer's specifications, or stored and labeled contrary to facility policies: 1.One (1) open latanoprost eye drop bottle for Resident 30 was found stored at room temperature and not labeled with a date on which storage at room temperature began. According to the manufacturer's product storage and labeling, opened latanoprost bottles may be stored at room temperature up to 77 degrees Fahrenheit and used or discarded within 6 weeks of opening/use. 2. One (1) unopened latanoprost eye drop bottle for Resident 45 was found stored at room temperature and not labeled with a date on which storage at room temperature began, with an additional blue label by pharmacy indicating to refrigerate. According to the manufacturer's product labeling, unopened latanoprost bottles should be stored in the refrigerator between 36 and 46 degrees Fahrenheit (ˆ) and used or discarded within 6 weeks of opening or once they've been stored at room temperature. During a concurrent interview, LVN 4 stated that the latanoprost eye drop bottles were not stored properly for Resident 30 and 45. LVN 4 stated multi-dose (containing more than one dose) medications, such as eye drop bottles, need to have a label indicating date of first use to know when they expire and be disposed. LVN 4 stated unopened latanoprost eye drop bottles should be stored in the refrigerator, as indicated by the pharmacy label, and opened latanoprost eye drop bottle should be disposed six (6) weeks after first use. LVN 4 stated that LVN 4 was unaware when both latanoprost bottles were placed at room temperature, and therefore unaware when the six (6) week expiration date was. LVN 4 stated that improperly stored eye drop medications and those used beyond the expiration date have lost potency, maybe contaminated (impure, unclean,) and will not be effective in treating the resident's condition, in addition causing eye infections since the bottle was no longer sterile (free of bacteria.) LVN 4 stated when using these latanoprost eye drop bottles for Resident 30 and 45 accidentally beyond six (6) weeks can cause adverse effects, not effectively treat the glaucoma, cause infections, further nerve damage and potentially lead to blindness. LVN 4 stated the latanoprost bottles for Resident 30 and 45 needed to be immediately removed from the medication cart and replaced with a new one from pharmacy. During an observation on [DATE] at 1:42 p.m., in Medication Cart East, with LVN 3 the following medications were found either stored in a manner contrary to their respective manufacturer's requirements, not labeled with an open date as required by their respective manufacturer's specifications, or stored and labeled contrary to facility policies: ˆ-One (1) open and used Rocklatan eye drop bottle for Resident 9 was found stored at room temperature and not labeled with a date on which storage at room temperature began. According to the manufacturer's product storage and labeling, opened Rocklatan bottles may be stored at room temperature 36 to 77 degrees Fahrenheit and used or discarded within 6 weeks of opening/use. During a concurrent interview, LVN (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055360	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakpark Healthcare Center	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3 stated that the Rocklatan eye drop bottle was a multi-dose medication, was open, used and not labeled with the date of first use. LVN 3 stated multi-dose medications need to have a label indicating date of first use to know when it expires and when to be disposed. LVN 3 stated according to the manufacturer guideline, Rocklatan eye drop bottle should be disposed six (6) weeks after first use to ensure the medication was still potent, and sterile (free from bacteria.) LVN 3 stated LVN 3 was unaware when the bottle was first used, and that the bottle was now considered expired. LVN 3 stated continued use of the Rocklatan eye drop bottle for Resident 9 was not effective in treating the resident's glaucoma and can harm the resident by causing eye infections and potential blindness. LVN 3 stated the Rocklatan eye drop bottle for Resident 9 needed to be removed from Medication Cart East and replaced with a new one from pharmacy. During an interview on [DATE] at 11:20 p.m., with the DON, the DON stated the latanoprost eye drop bottle for Resident 30 and Rocklatan for Resident 9 were not labeled with a date when first used, and the latanoprost for Resident 45 was not stored in the refrigerator. The DON stated eye drop bottles were considered multi-dose medications and opened bottles had six (6) week expiration dates to ensure the medications were potent, sterile and not contaminated. The DON stated these eye drop bottles were now considered expired, have potentially lost their efficacy due to improper storage and no longer considered sterile. The DON stated these failures could lead to the administration of expired and ineffective latanoprost to Resident 30 and 45, and Rocklatan to Resident 9 resulting in not effectively treating glaucoma, and leading to eye nerve damage, infections and possible blindness. The DON stated severed LVNs failed to store latanoprost for Resident 45 in the refrigerator and latanoprost for Resident 30 and failed to label Rocklatan for Resident 9 with a date indicating when use began. During a review of the facility's policy and procedures (P&P), titled Administering Medications, last reviewed [DATE], the P&P indicated 12. When opening a multi-dose container, the date opened is recorded on the container. During a review of the facility's P&P, titled Storage of Medications, last reviewed [DATE], the P&P indicated: 7. Medications requiring refrigeration are stored in the refrigerator. During a review of manufacturer's guide Highlights of Prescribing Information for latanoprost dated [DATE], the guide indicated Protect from light. Store unopened bottle(s) under refrigeration at 36 to 46 F. Once a bottle is opened for use, it may be stored at room temperature up to 77 F for 6 weeks. Serious damage to the eye and subsequent loss of vision may result from using contaminated solutions. During a review of manufacturer's guide Highlights of Prescribing Information for Rocklatan dated [DATE], the guide indicated Protect from light. After opening, the product may be kept at 36 F to 77 F for up to 6 weeks. Serious damage to the eye and subsequent loss of vision may result from using contaminated solutions.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055360	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakpark Healthcare Center	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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the physician when one of two sampled residents (Resident 15) reviewed under the hospitalization care area, did not receive enoxaparin sodium solution (commonly known by the brand name Lovenox, a medication used to prevent and treat harmful blood clots) as ordered by the physician. This failure in lack of timely notification had the potential to result in delayed care and treatment which had the potential to increase the risk of blood clots, such as deep vein thrombosis (DVT-a serious condition where a blood clot forms in a deep vein, usually in the legs, causing pain, swelling, warmth, and redness) to Resident 15. Findings: During a review of Resident 15's admission Record, the admission Record indicated the facility admitted Resident 15 to the facility on 9/16/2021 and readmitted on [DATE] with diagnoses including dysphagia (difficulty swallowing), type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar), and hypertension (a chronic high blood pressure). During a review of Resident 15's Health and Physical (H&P) dated 1/31/2026, the H&P indicated Resident 15 does not have capacity to understand and make decisions. During a review of Resident 15's Minimum Data Set (MDS - a resident assessment tool), dated 2/19/2026, the MDS indicated Resident 15 had moderate cognitive (ability to make decisions, understand, learn) impairment. The MDS also indicated, Resident 15 was dependent (helper does all of the effort) for showering, required substantial maximal assist (helper does more than half) with toileting hygiene, and required partial/moderate assist (helper does less than half) with eating, upper and lower body dressing. During a review of Resident 15's Physician Order Report dated 4/7/2026, the Physician Order Report indicated an order dated 10/6/2026, with a start date of 10/7/2024 for enoxaparin sodium solution 40 milligrams (mg-unit of measurement)/0.4 milliliters (ml-unit of volume), one dose to be injected subcutaneously (administered into the fatty tissue layer between the skin and muscle, often in the abdomen or upper arm) one time a day for DVT and to rotate sites. During a review of Resident 15's Medication Administration Record (MAR) dated 3/1/2026 to 3/31/2026, the MAR indicated that the box designated for documenting the administration of enoxaparin sodium solution 40 mg/0.4 ml subcutaneously once daily was marked with 9. The MAR indicated that 9 is a chart code for Other/See Progress Notes. During a review of Resident 15's Administration Note dated 3/13/2026 at 4:49 p.m., documented by Licensed Vocational Nurse 2 (LVN 2), the note indicated Resident 15 did not receive the medication and it needed to be reordered. During an interview on 4/7/2026 at 4:06 p.m., with the Director of Nursing (DON), the DON stated Resident 15 did not receive the Lovenox injection as ordered by physician on 3/13/2026. The DON stated that Resident 15 is non- ambulatory, and the potential outcome of not receiving Lovenox as ordered could include the development of DVT and/or a heart attack (occurs when blood flow to the heart is blocked, causing muscle tissue to die). The DON explained that if a medication is not available on the unit, nursing staff are expected to check the emergency kit (EKit-a supply of medications kept at the facility for immediate use in urgent situations, before a pharmacy can deliver the resident's prescribed medication) and obtain the medication from there or request a STAT (immediately or now) delivery from the pharmacy. The DON stated that Lovenox 40 mg was available in the EKit on 3/13/2026, and LVN 1 should have obtained the medication from the EKit to administer it as ordered. The DON stated the physician should have been notified that Resident 15 did not receive the medication, in order to determine whether new orders or adjustments to the medication dosage were needed. During an interview on 4/7/2026 at 4:34 p.m., with LVN 2, LVN 2 stated that Resident 15 is non-ambulatory and physician ordered the Lovenox injection for DVT prophylaxis. LVN 2 stated she was the nurse assigned to Resident 15 on 3/13/2026 from 3 p.m. to 11 p.m. LVN 2 stated she did not administer Lovenox because the medication was not (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055360	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakpark Healthcare Center	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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	available at the time of the scheduled dose.ˆLVN 2ˆstatedˆshe did not check the EKit to verify whether the medication was available.ˆLVN 2ˆfurtherˆstatedˆthat the potential outcome of Resident 15 not receivingˆLovenoxˆas ordered include blood clot formation, DVT, and other related complications.ˆLVN 2 stated she did not inform the physician and instead waited for the pharmacy to deliver the medication. LVN 2 stated she should have informed the physician the medication was not administered to Resident 15 determine whether the physician would have new orders. Duringˆaˆreview of the facility's policy and procedureˆ(P&P)ˆtitledˆ Anticoagulation- Clinical Protocol,ˆreviewed onˆ10/29/2025, the P&Pˆindicatedˆthatˆthisˆthe nurse shall document/report current anticoagulation therapy, including drug and current dosage. The physician will order measures to address any complications, including holding or discontinuing the anticoagulant as indicated Duringˆaˆreview of the facility's policy and procedureˆ(P&P)ˆtitledˆ MedicationˆAdministrationˆreviewedˆonˆ10/29/2025, the P&Pˆindicatedˆmedicationsˆare administered in a safe andˆtimelyˆmanner, and as prescribed.ˆMedications are administered in accordance with prescriber orders, including any required time frame. Medications are administered within one (I) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). If a dosage is believed to be inappropriate or excessive for a resident. or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication will contact the prescriber, the residents attending physician or the facility's medical director to discuss the concerns. If a dosage is believed to be inappropriate or excessive for a resident. or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication will contact the prescriber, the residents attending physician or the facility's medical director to discuss the concerns. Duringˆaˆreview of the facility's policy and procedureˆ(P&P)ˆtitledˆ Adverse Consequences and Medication Errors,ˆreviewed onˆ10/29/2025, the P&Pˆindicatedˆexamplesˆofˆmedications errorsˆincludeˆomission - a drug is ordered but not administered. Duringˆaˆreview of the facility's policy and procedureˆ(P&P)ˆtitledˆ Change in a Resident's Condition or Status,ˆreviewed onˆ10/29/2025, the P&Pˆindicatedˆthatˆthisˆthe facility promptly notifies the resident his or her attending physician. and the resident representative of changes in the resident's medical/mental condition and/or status (e.g changes in level of care. billing/payments. resident rights.). need to alter the resident's medical treatment significantly. ˆˆ ˆˆˆ

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055360	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakpark Healthcare Center	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)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, and record review, the facility failed to provide a homelike environment for one out of four residents (Resident 24) investigated under the Environment task when the padding covering the resident's side rail (adjustable rigid plastic or metal bars attached to the bed that may be positioned in various locations on the bed; upper or lower, either or both sides) was ripped. This deficient practice created the potential for Resident 24 to experience an unsanitary and uncomfortable environment. Findings: During a review of Resident 24's admission Record, the admission Record indicated the facility originally admitted the resident on 9/12/2022 and most recently readmitted the resident on 7/15/2024 with diagnoses including, but not limited to, aftercare following a joint replacement surgery and Parkinsonism (neurological conditions causing slowed movement, rigidity, tremors, and postural instability). During a review of Resident 24's Minimum Data Set (MDS- a resident assessment tool), dated 1/2/2026, the MDS indicated the resident had moderate cognitive impairment (trouble with thinking, learning, and remembering clearly). The MDS indicated Resident 24 required moderate assistance (helper does less than half of the effort) for most activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 24's Order Summary Report, the Order Summary Report indicated an order dated 4/22/2025, for padded side rails while in bed to enable the resident with bed mobility. During an observation on 4/6/2026 at 8:15 a.m. at Resident 24's bedside, Resident 24 was in bed and the side rails were covered with black foam padding. The padding was ripped on the lower portion of the left side rail, leaving a portion of the bed rail exposed. During a concurrent observation and interview on 4/9/2026 at 10:53 a.m. with Housekeeper (HKP) 1 at Resident 24's bedside, HKP 1 stated that the padding over the resident's side rail is ripped and she cannot clean it so she would report it to her supervisor so they can replace it. During an interview on 4/9/2026 at 11:30 a.m. with the Director of Nursing (DON), the DON stated the ripped padding looks bad and due to the missing portion of the padding the resident could bump against the side rail and hurt herself. During a review of the facility's policy and procedure (P&P) titled, Homelike Environment, last reviewed on 10/29/2025, the P&P indicated residents are provided with a safe, clean, comfortable, and homelike environment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055360	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakpark Healthcare Center	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)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one (1) of five (5) sampled residents' (Resident 24) Minimum Data Set (MDS, a standardized assessment and care-screening tool) accurately reflected the resident's behavior indicators for psychosis (a mental health condition where a person loses touch with reality, making it difficult to distinguish what is real from what is not).This deficient practice had the potential to result in incorrect plan of care, services, interventions and psychotherapeutic (any medication capable of affecting the mind, emotions, and behavior) medications for Resident 24. Findings: During a review of Resident 24's admission Record (a document containing demographic and diagnostic information,) dated 4/7/2026, the record indicated Resident 24 was originally admitted to the facility on [DATE] and re-admitted on [DATE] with diagnosis including Parkinsonism (a disorder that causes movement problems such as slowness, stiffness, tremors, and balance issues,) psychotic disorder, depression, anxiety, insomnia (difficulty sleeping.) During a review of Resident 24's MDS dated [DATE], the MDS indicated Resident 24 had Brief Interview for Mental Status (BIMS) score of 12 indicating moderately impaired cognition for daily decision making, had no symptoms of feeling down, depressed or hopeless, and was not marked for having hallucinations (sensing things such as visions, sounds, or smells that seem real but are not) or delusions (false beliefs not based in reality), and was taking antipsychotics (drugs primarily used to treat psychosis) on a routine basis. During a review of Resident 24's Medication Administration Record (MAR - a record of medications administered to residents), for December 2025, the MAR indicated Resident 24 was prescribed the following: -Nuplazid 34 milligrams (mg-unit of measurement) one (1) capsule orally once a day for Parkinson's induced psychosis manifested by verbalizing auditory and visual hallucinations that people are after her, to give at 9 a.m. -Monitor with hashmark every shift for episodes of Parkinson's induced psychosis manifested by verbalizing auditory and visual hallucinations that people are after her for Nuplazid use. There were total of 54 episodes of psychosis manifested by verbalizing auditory and visual hallucinations that people are after her marked on the following days and shifts: 21 episodes for 7 a.m. to 3 p.m. shift in December 2025 22 total episodes for 3 p.m. to 11 p.m. shift in December 2025 11 total episodes for 11 p.m. to 7 a.m. shift in December 2025 -Quetiapine 25 mg one (1) tablet orally in the afternoon for psychosis manifested by delusions and visual hallucinations, to give at 2:30 p.m. -Monitor with hashmark every shift for episodes of psychosis manifested by delusions and visual hallucinations for quetiapine use. There were total of 77 episodes of psychosis manifested by delusions and visual hallucinations on the following days and shifts: 27 episodes for 7 a.m. to 3 p.m. shift in December 2025 27 total episodes for 3 p.m. to 11 p.m. shift in December 2025 23 total episodes for 11 p.m. to 7 a.m. shift in December 2025 During a concurrent document review and interview on 4/7/2026 at 2:35 p.m., with the Director of Nursing (DON,) the DON reviewed Resident 24's MDS dated [DATE] and December 2025 MAR. The DON acknowledged the MAR indicated Resident 24 had 77 episodes of delusions and visual hallucinations marked for quetiapine use, and 54 episodes of psychosis manifested by verbalizing auditory and visual hallucinations that people are after her for Nuplazid use. The DON acknowledged the MDS was an assessment for the timeframe prior to 1/2/2026, and that it indicated Resident 24 had no behaviors of having delusions or hallucinations prior to 1/2/2026. The DON acknowledged the discrepancy between December 2025 MAR and 1/2/2026 MDS, and stated that the facility failed to accurately mark and transmit (submit) the 1/2/2026 MDS. The DON stated the MDS needed correction. During a review of facility Policy and Procedures (P&P,) titled Electronic submission of the MDS, last reviewed 10/29/2025, the P&P indicated The MDS coordinator is responsible for ensuring that appropriate edits are made prior to transmitting MDS data.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055360	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakpark Healthcare Center	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility^failed to^document the presence or absence of seizure (a sudden, uncontrolled burst of electrical activity in the brain that disrupts normal brain function) activity and failed to^monitor^for complications associated with anti-seizure medications for one of one sampled resident (Resident 40). These deficient practices had the potential to delay the timely identification of changes in Resident 40's condition, which could result in delayed interventions and adverse outcomes. Findings:^ ^^ During a review of Resident 40's admission Record, the admission Record^indicated^the facility admitted Resident 40 to the facility on 2/21/2026 and readmitted on [DATE] with diagnoses^that included epilepsy (chronic neurological condition characterized by recurrent, unprovoked seizures (a sudden, uncontrolled electrical disturbance in the brain, causing changes in behavior, consciousness, movements, or feelings), type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar), and^ hypertension (a chronic high blood pressure).^ During a review of^the^Health and^Physical (H&P) dated 4/6/2026, the H&P^indicated^Resident 40 has a diagnosis of seizure (a sudden, uncontrolled electrical disturbance in the brain, causing changes in behavior, consciousness, movements, or feelings).^^ During a review of Resident 40's Minimum Data Set (MDS - a resident assessment tool), dated 2/25/2026, the MDS indicated Resident 40 had moderate to severe cognitive (ability to make decisions, understand, learn) impairment. The MDS indicated Resident 40^required^partial to moderate assist (helper does less than half of the effort) with rolling^left and right, sit to lying, lying to sitting on side of the bed. The MDS indicated that Resident 40 required substantial/maximal^assistance^(helper does more than the effort) with sit to stand, chair toilet^transfer^and toilet transfer.^^ During a review of Resident 40's Physician Order Report^dated^4/9/2026, the Physician Order Report^indicated^an order^dated 4/2/2026, with the start date of 4/3/2026^to give^Levetiracetam (anti-seizure medication)^oral (by mouth) tablet 250^milligrams (mg -unit of measurement)^two times a day for seizure disorder.^ During a review of Resident 40's Medication Administration Record (MAR) dated 4/01/2026 to 4/30/2026, the MAR^indicated^Resident 40 received Levetiracetam two times a day for seizure disorder from 4/3/2026 to 4/8/2026.^ ^ During a review of Resident 40's Licensed Progress Note dated 3/28/2026 timed at 7:25 P.M.,^the Licensed Progress Note^indicated^on 3/28/2026 at 7:25 P.M., Resident 40 was in bed while experiencing^a^seizure.^Resident 40^was^transferred to^the^hospital via 911 (emergency services you call for immediate help in urgent situations such as medical emergencies, fires, or crimes)^^ During^concurrent^interview and record review on 4/8/2026 at^1:37^p.m., with the Director of Nursing (DON),^Resident 40's^medical record^including progress^notes, communication^notes, and^MAR^from^4/02/2026 to^4/8/2026 were reviewed.^The DON^stated^that she could not^provide any documentation showing that the licensed nurses^are monitoring and documenting presence and absence of seizure activity in accordance with the facility's policy.^The DON stated that it was important to monitor and document the presence and absence of seizure activity to identify changes in the resident's condition During an interview on 4/9/2026 at^8:54^a.m., with^Licensed Vocational^Nurse (LVN)^1, LVN^1^stated^that Resident 40 has a seizure diagnosis,^and licensed nurses are required to monitor and document seizure activity each shift, including any side or adverse (unwanted or negative) effects of ant-seizure medications.During a concurrent interview and record review on 4/9/2026 at 8:58 a.m., with LVN 1, Resident 40's medical record including progress notes, communication notes and MAR from 4/2/2026 to 4/8/2026 were reviewed. LVN 1 stated that she could not provide documentation showing the licensed nurses were monitoring and documenting presence or absence of seizure activity based on the facility's policy. During^a^review of the facility's P&P^titled Seizures and Epilepsy - Clinical Protocol,^revised on^10/29/2025, the P&P^indicated^the^staff,^and physician will^monitor^the progress of individuals with a new seizure or a seizure^disorder and^will^modify^interventions (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055360	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakpark Healthcare Center	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	accordingly.ˆThey should document periodically and objectively the presence or absence of seizure activity.ˆThe staff and physician willˆmonitorˆfor complications related to antiepilepticˆmedications,ˆfor example, dizziness, ataxia,ˆsomnolence, headache, diplopia, blurredˆvision, nausea, vomiting, and rash.ˆ

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055360	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakpark Healthcare Center	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record, the facility failed to provide an environment that is free from accident hazards for one of one sampled resident (Resident 40) by failing to provide a padded side rail to Resident 40, who has a diagnosis of epilepsy (chronic neurological condition characterized by recurrent, unprovoked seizures [a sudden, uncontrolled electrical disturbance in the brain, causing changes in behavior, consciousness, movements, or feelings])This deficient practice placed the resident at increased risk for injury and harm. Findings:During a review of Resident 40's admission Record, the admission Recordˆindicatedˆthe facility admitted Resident 40 to the facility on 2/21/2026 and readmitted on [DATE] with diagnosesˆthat included epilepsy (chronic neurological condition characterized by recurrent, unprovoked seizures (a sudden, uncontrolled electrical disturbance in the brain, causing changes in behavior, consciousness, movements, or feelings), type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar), andˆ hypertension (a chronic high blood pressure).ˆ During a review ofˆtheˆHealth andˆPhysical (H&P) dated 4/6/2026, the H&Pˆindicatedˆ Resident 40 has a diagnosis of seizure (a sudden, uncontrolled electrical disturbance in the brain, causing changes in behavior, consciousness, movements, or feelings).ˆˆ During a review of Resident 40's Minimum Data Set (MDS - a resident assessment tool), dated 2/25/2026, the MDS indicated Resident 40 had moderate to severe cognitive (ability to make decisions, understand, learn) impairment. The MDS indicated Resident 40ˆrequiredˆpartial to moderate assist (helper does less than half of the effort) with rollingˆleft and right, sit to lying, lying to sitting on side of the bed. The MDS indicated that Resident 40 required substantial/maximalˆassistanceˆ(helper does more than the effort) with sit to stand, chair toiletˆtransferˆand toilet transfer.ˆˆ During a review of Resident 40's Physician Order Reportˆdatedˆ4/9/2026, the Physician Order Reportˆindicatedˆan orderˆdated 4/2/2026, with the start date of 4/3/2026ˆto giveˆLevetiracetam (anti-seizure medication)ˆoral (by mouth) tablet 250ˆmilligrams (mg -unit of measurement)ˆtwo times a day for seizure disorder.ˆ During a review of Resident 40's Licensed Progress Note dated 3/28/2026 timed at 7:25 P.M.,ˆthe Licensed Progress Noteˆindicatedˆon 3/28/2026 at 7:25 P.M., Resident 40 was in bed while experiencingˆaˆseizure.ˆResident 40ˆwasˆtransferred toˆtheˆhospital via 911 (emergency services you call for immediate help in urgent situations such as medical emergencies, fires, or crimes).During a concurrent observation and interview on 4/8/2026 at 1:34 p.m., with the Director of Nursing (DON) in Resident 40's s room, Resident 40's metal side rail observed with no padding. The DON stated Resident 40 had a seizure and was transferred to hospital due to seizure recently. The DON stated Resident 40's side rails must be padded to prevent potential injury during seizures. During a review of the facility's P&P titled Safety and Supervision of Residents, revised on 10/29/2025, the P&P indicated the facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents arc facility-wide priorities. Our individualized, resident-centered approach to safety addresses safety and accident hazards for individual residents. The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices. Due to their complexity and scope, certain resident risk factors and environmental hazards are addressed in dedicated policies and procedures. These risk factors and environmental hazards include the following: Bed Safety.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055360	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakpark Healthcare Center	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)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a window screen did not have a gap that may be a potential entry point of insects into a shared resident room affecting two of four residents (Residents 19 and 38) investigated under the Environment task. This deficient practice created an entry point and access for insects to get inside the building which can potentially transmit insect borne illnesses and negatively affect the residents' quality of life. Findings: During a review of Resident 19's admission Record, the admission Record indicated the facility originally admitted the resident on 5/5/2023 and most recently readmitted the resident on 6/20/2025 with diagnoses including, but not limited to, Parkinsonism (neurological conditions causing slowed movement, rigidity, tremors, and postural instability), acute (a medical issue with a sudden onset and short duration) respiratory failure (a condition where the lungs cannot release enough oxygen into the blood), and dementia (a progressive state of decline in mental abilities). During a review of Resident 19's Minimum Data Set (MDS-resident assessment tool), dated 2/13/2026, the MDS indicated the resident was rarely or never able to express ideas or wants and rarely or never understood others. The MDS indicated Resident 19 required substantial assistance (helper does more than half of the effort) for all activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 38's admission Record, the admission Record indicated the facility originally admitted the resident on 10/11/2023 and most recently readmitted the resident on 3/6/2026 with diagnoses including, but not limited to, metabolic encephalopathy (the loss of brain function due to a chemical imbalance in the blood) and chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing). During a review of Resident 38's MDS, dated [DATE], the MDS indicated the resident had intact cognition (can think, learn, remember, use judgement, and make decisions). The MDS indicated Resident 38 required moderate assistance (helper does less than half of the effort) for most ADLs. During an observation on 4/9/2026 at 10:16 a.m. in Resident 19 and Resident 38's shared room, the window facing outside the facility was open and contained a screen which was bent creating a gap between the window screen and the window. During a concurrent observation and interview on 4/9/2026 at 11:05 a.m., with the Maintenance Supervisor (MS) in Resident 19 and Resident 38's shared room, the MS validated the window screen was bent. The MS stated there was an approximate inch wide gap at the bottom and half an inch gap at the side creating openings with no window screen. The MS stated he would need to straighten the window screen and screw it to the window frame to fix the gaps. The MS stated insects and dust could come into the room through the gaps. During an interview on 4/9/2026 at 11:30 a.m. with the Director of Nursing (DON), the DON stated the screen should be flush with the window with no gaps so no insects can come into the room. During a review of the facility's policy and procedure (P&P) titled, Pest Control, last reviewed on 10/29/2025, the P&P indicated the facility will maintain an effective pest control program and that windows are to be screened at all times. During a review of the facility's P&P titled, Homelike Environment, last reviewed on 10/29/2025, the P&P indicated residents are provided with a safe, clean, comfortable, and homelike environment.