

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056148	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2025
NAME OF PROVIDER OR SUPPLIER Casitas Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 10626 Balboa Blvd. Granada Hills, CA 91344	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39550</p> <p>Based on interview and record review, the facility failed to ensure prompt attempts were made to resolve the grievance of one of three sampled residents (Resident 1).</p> <p>This deficient practice violated the residents' right to have his grievance addressed.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record, the Admission Record indicated the facility admitted Resident 1 on 4/27/2025 and readmitted on [DATE] with diagnoses that included pneumonitis (general inflammation of lung tissue) due to inhalation of food and vomit, urinary tract infection (UTI-an infection in the bladder/urinary tract), and gastrostomy status (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems).</p> <p>During a review of Resident 1's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 3/6/2025, the MDS indicated Resident 1 had severely impaired cognition. The MDS also indicated Resident 1 was dependent on staff with oral hygiene, toileting hygiene, and personal hygiene.</p> <p>During a review of Resident 1 ' Social Service Note, dated 3/20/2025, at 3:06 p.m., the Social Service Note indicated, Social Services Director (SSD) received a call from the Resident 1's family member (FM 1) regarding some concerns with nursing care. The note further indicated the SSD told FM 1 that SSD would speak to the Administrator (ADM) regarding FM 1's concerns. The SSD notified the Administrator regarding the FM's concerns.</p> <p>During a review of Concern/Grievance Log, there was no documented evidence of a grievance filed for Resident 1 for the months of January 2025, February 2025, and March 2025.</p> <p>During an interview on 4/1/2025 at 10:23 a.m., with FM 1, FM 1 stated that FM 1 spoke to the SSD regarding concerns about the care being provided to Resident 1, however, FM 1 stated that no one from the facility staff followed up with FM 1 to address FM 1's concerns.</p> <p>(continued on next page)</p>

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056148	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2025
NAME OF PROVIDER OR SUPPLIER Casitas Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 10626 Balboa Blvd. Granada Hills, CA 91344	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 4/1/2025 at 4:18 p.m., with the SSD, reviewed the facility ' s Concern/Grievance Log for the months of January 2025, February 2025, and March 2025. The SSD stated that if a grievance/concern is reported the SSD will ask the resident or responsible party if they would like to file a grievance. The SSD stated that the report is then taken to the ADM and the Director if Nursing (DON). The SSD further stated that the SSD received a call from FM 1 on 3/20/2025, during which FM 1 reported concerns about the care being provided to Resident 1. The SSD stated that there is no documentation of a grievance from FM 1 documented in the Concerns/Grievance Log.</p> <p>During an interview on 4/1/2025 at 4:29 p.m., with the ADM, the ADM stated that the SSD informed the ADM of the concerns that FM 1 reported. The ADM stated that because the concerns are nursing related, the ADM reported to the DON.</p> <p>During an interview on 4/1/2025 at 4:37 p.m., with the DON, the DON stated that Resident 1 ' s family usually have concerns that are addressed immediately. The DON stated she did not follow up with FM 1 regarding the concerns FM 1 reported on 3/20/2025. The DON stated that she got busy and forgot about FM 1 ' s concerns.</p> <p>During a follow up interview on 4/1/2025 at 4:50 p.m., with the SSD, the SSD stated that the SSD was too busy to follow up FM 1 ' s concerns. The SSD stated that a grievance/concern form and log should have been completed so that the appropriate follow up could have been done.</p> <p>During a review of the facility's policy and procedure titled Grievances/Complaints, Filing, reviewed date 1/3/2025, the policy and procedure indicated residents and their representatives have the right to file grievances, either orally or in writing, to the facility staff or to the agency designated to hear grievances. The Administer and staff will make prompt efforts to resolve grievances to the satisfaction of the resident and/or representative. Any resident, family member, or appointed resident representative may file a grievance or complaint concerning care, treatment, behavior of other residents, staff members, theft of property, or any other concerns regarding his or her stay at the facility. All grievances, complaints or recommendations stemming from resident or family groups concerning issues of resident care in the facility will be considered. Actions on such issues will be responded to in writing, including a rationale for the response. Upon receipt of a grievance and/or complaint, the Grievance Officer will review and investigate the allegations and submit a written report of such findings to the Administrator within five (5) working days of receiving the grievance and/or complaint. The resident, or person filing the grievance and/or complaint on behalf of the resident, will be informed (verbally and in writing) of the findings of the investigation and the actions that will be taken to correct any identifying problems.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056148	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2025
NAME OF PROVIDER OR SUPPLIER Casitas Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 10626 Balboa Blvd. Granada Hills, CA 91344	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide for the safe, appropriate administration of IV fluids for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39550</p> <p>Based on interview and record review the facility failed to ensure the facility ' s intravenous (IV -fluids given directly into the blood stream) administration policy was implemented to prevent complications from intravenous therapy by failing to monitor a resident receiving intravenous hydration for Intake & Output (I&O- the careful tracking and recording of fluids a patient consumes [intake] and eliminates [output] to monitor fluid balance and overall hydration status) and failed to assess a resident prior to the administration of IV fluids for one of three sampled residents (Resident 1)</p> <p>This deficient practice had the potential to place Resident 1 at risk for developing complications such as inflammation of the vein, fluid overload (a medical condition characterized by having too much fluid volume in the body, potentially leading to health complications like swelling, high blood pressure, and heart problems), electrolyte (minerals in your blood and other body fluids that carry an electric charge) imbalances , and infection.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record, the Admission Record indicated the facility admitted Resident 1 on 4/27/2025 and readmitted on [DATE] with diagnoses that included pneumonitis (general inflammation of lung tissue) due to inhalation of food and vomit, urinary tract infection (UTI-an infection in the bladder/urinary tract), gastrostomy status (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems).</p> <p>During a review of Resident 1's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 3/6/2025, the MDS indicated Resident 1 had severely impaired cognition. The MDS also indicated Resident 1 was dependent on staff with oral hygiene, toileting hygiene, and personal hygiene.</p> <p>During a review of Resident 1 ' s physician ' s order dated 3/3/2025 at 5:28 p.m., the physician order indicated the followinmg order:</p> <p>-D5W (a mixture of dextrose (glucose) and water) x 1 liter at 50cc (cubic centimeter- a unit of volume equal to one milliliter)/hr. (hour) every Tuesday & Friday one time a day every Tuesday, Friday. IV (Intravenous) Hydration. Start date: 3/4/2025</p> <p>a. During a concurrent interview and record review on 4/1/2025 at 11:39 a.m. with Registered Nurse 1 (RN 1), reviewed Resident 1 ' s physicians orders. RN 1 stated that Resident 1 had an order for D5W x 1 liter at 50cc/hr. every Tuesday & Friday one time a day every Tuesday and Friday for hydration. RN 1 stated that the facility monitors I&O for 30 days only if the IV fluids order is a new order. After 30 days the facility no longer monitors I&O. RN 1 reviewed Resident 1 ' s physical chart and electronic medical record and stated that there was no documented evidence found that Resident 1 ' s I&O was monitored. RN 1 stated that the facility did not monitor Resident 1's I&Os because Resident 1 has been on IV hydration per the family ' s request for a few months and did not need to be monitored. RN 1 further stated that Resident 1 ' s I&Os should have been monitored and documented to see if Resident 1 was in fluid overload, if Resident 1 was retaining fluid, or if there was anything wrong, the facility could inform the physician for further interventions.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056148	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2025
NAME OF PROVIDER OR SUPPLIER Casitas Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 10626 Balboa Blvd. Granada Hills, CA 91344	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 4/1/2025 at 2:30 p.m. with the Medical Records Director (MRD), the MRD reviewed Resident 1 ' s medical records and stated that there was no documented evidence of Resident 1's I&O.</p> <p>During a review of the facility's policy and procedure titled Intravenous Administration of Fluids and Electrolytes, reviewed 1/3/2025, the policy and procedure indicated the purpose of this procedure is to provide guidelines for the safe and aseptic administration of intravenous fluids and electrolytes for hydration. Under steps in the procedure document procedure in the resident ' s medical record and on the intake/output record.</p> <p>b. During an interview on 4/1/2025 at 3:30 p.m., with RN 1, RN 1 stated she did not assess Resident 1's lung/heart status and vital signs, prior to administering IV fluids because there was no physician's order. RN 1 stated that it is important to assess heart/lung status and vital signs prior to giving IV fluid hydration to monitor if Resident 1 was experiencing any complications due to the IV fluids such as fluid overload.</p> <p>During a review of the facility's policy and procedure titled Intravenous Administration of Fluids and Electrolytes, reviewed 1/3/2025, the policy and procedure indicated under preparation assess resident ' s lung and heart status and vital signs before and during therapy to assess for fluid overload. Under general guidelines, Resident should be monitored frequently, per facility policy, when continuous fluids are infusing. Monitor for signs and symptoms of fluid overload, catheter and insertion site complications, and the resident ' s tolerance of the procedure. Fluids may be stopped by a nurse if signs of program are present.</p>