

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 04/25/2025
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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42275</p> <p>Based on interview and record review, the facility failed to:</p> <ol style="list-style-type: none"> 1. Notify one of four sampled residents (Resident 1) physician and Resident 1 regarding the missed dose of Levothyroxine Sodium (levothyroxine - a medication used to treat an underactive thyroid gland [a gland that makes and stores hormones that help regulate the heart rate, blood pressure, body temperature, growth development and energy]) scheduled to be given on 1/15/2025 at 6:30 a.m. 2. Notify one of four sampled residents (Resident 1) physician of Resident 1's refusal to allow body weight monitoring for a duration of 58 days (2/6/2025 to 4/4/2025). <p>These deficient practices may result in worsening symptoms, increased risk of hospitalization or complications and health decline.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During a review of Resident 1's Admission Record, the Admission Record indicated the facility originally admitted the resident on 1/14/2025 and readmitted on [DATE] with diagnoses that included hypothyroidism (when the thyroid gland doesn't make enough thyroid hormones to meet your body needs), diabetes mellitus (DM - a condition that happens when your blood sugar is too high), hypertension (abnormally high blood pressure), and morbid (severe) obesity (a medical condition where someone has excessive fat accumulation that presents a risk to health). <p>During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 4/14/2025, the MDS indicated Resident 1's cognition (mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was intact. The MDS further indicated that Resident 1 required maximum assistance from staff with lower body dressing and transfer, moderate assistance with bed mobility and toileting hygiene, and independent with eating.</p> <p>During a review of Resident 1's Order Summary Report, dated 1/14/2025, the Order Summary Report indicated levothyroxine 75 microgram (mcg - a unit of measurement); give one tablet by mouth in the morning for hypothyroidism.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 1's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) dated 1/15/2025, the MAR indicated to administer levothyroxine 75 mcg at 6:30 a.m. however Registered Nurse 2 (RN 2) documented 'Other'.</p> <p>During a review of Resident 1's Progress Notes; Type - Medication Administration Note, dated 1/15/2025, timed at 7:03 a.m., indicated Resident 1 was newly admitted and awaiting delivery of levothyroxine 75 mcg from the pharmacy.</p> <p>During a concurrent interview and record review on 4/24/2025 at 10:14 a.m. with the Director of Nursing (DON), the DON reviewed Resident 1's physician order for levothyroxine dated 1/14/2025 and Resident 1's MAR for levothyroxine dated 1/15/2025, with scheduled administration time of 6:30 a.m. The DON stated that levothyroxine was not administered to Resident 1 on 1/15/2025 at 6:30 a.m. because the medication (levothyroxine) was not yet delivered to the facility. The DON further stated there was no documented evidence found indicating levothyroxine was given to Resident 1 upon receipt. The DON stated there was no documented evidence found Resident 1's physician was notified about the missed levothyroxine dose on 1/15/2025.</p> <p>During a concurrent interview and record review on 4/25/2025 at 4:35 p.m. with the Director of Staff Development (DSD), the DSD reviewed Resident 1's physician order for levothyroxine dated 1/14/2025, Resident 1's MAR for levothyroxine dated 1/15/2025, with scheduled administration time of 6:30 a.m. and the Medication Administration Audit Record for levothyroxine dated 1/15/2025 at 7:03 a.m. The DSD stated Resident 1's physician should have been notified that levothyroxine was not available to be administered on 1/15/2025 at 6:30 a.m. and should have been documented in Resident 1's clinical record.</p> <p>During an interview on 4/25/2025 at 4:57 p.m. with Resident 1, Resident 1 stated that she (Resident 1) has not been informed of the missed levothyroxine dose on 1/15/2025.</p> <p>2. During a review of Resident 1's Order Summary Report, dated 1/14/2025, the Order Summary Report indicated to obtain weekly weights for four weeks one time a day every Wednesday for four weeks. Order Date 1/14/2025; Start Date 1/15/2025; and End Date 2/12/2025.</p> <p>During a review of Resident 1's Physician Order Summary, dated 4/9/2025, timed at 12:38 p.m. indicated to obtain weekly weights for four weeks. Order Date 4/9/2025.</p> <p>During a review of Resident 1's Weights and Vitals Summary dated 4/24/2025, the Weight Summary indicated Resident 1's weights as follows:</p> <p>a. A strikethrough entry (often called a strikeout, is a formatting style where a horizontal line is drawn to indicate that the entry or information has been deleted) dated 1/18/2025, timed at 2:31 p.m. indicated Resident 1 weighs 309 pounds (lbs. - an abbreviation for pounds which is a unit of weight) measured by bed scale (a specialized weighing device designed to weigh residents who are bedridden or unable to stand).</p> <p>b. A strikethrough entry dated 1/30/2025, timed at 8:37 a.m. and 3:16 p.m. indicated Resident 1 weighs 265 lbs. measured by mechanical lift (a device used to assist in the movement and transfer of individuals who need help with mobility due to limitations in weight-bearing or movement ability).</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>c. An entry dated 1/31/2025 timed at 9:12 a.m. entered by the Director of Nursing (DON) indicated declined order.</p> <p>During a concurrent interview and record review on 4/24/2025 at 10:05 a.m., with the DON, the DON reviewed Resident 1's Weight Summary dated 4/24/2025. The DON stated Resident 1's weight was last checked on 1/30/2025. The DON stated Resident 1 had been refusing to be weighted since then. The DON stated she (DON) was unable to locate documentation of Resident 1's refusal to have her (Resident 1) weight checked and unable to locate documentation indicating Resident 1's physician was notified.</p> <p>During a concurrent interview and record review on 4/24/2025 at 10:11 a.m., with RN 1, RN 1 reviewed Resident 1's progress notes and care plans (from Resident 1's original admitted [DATE] to 4/23/2025). RN 1 stated that RN 1 did not receive reports from any staff that Resident 1 had been refusing to be weighed. RN 1 stated she was unable to locate entries in Resident 1's progress notes and care plans (from 1/14/2025 to 4/23/2025) regarding Resident 1's refusal to be weighed. When RN 1 was asked what the facility protocol was for a resident refusing to be weigh, RN 1 stated that the facility should notify the physician and develop a care plan to address Resident 1's refusal to allow body weight monitoring. RN 1 further stated there was no documented evidence found indicating Resident 1's physician was notified of Resident 1's refusal to allow body weight monitoring.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Weight Assessment and Intervention last reviewed 1/3/2025, indicated, The nursing staff will measure resident weights on admission, the next day, and weekly for two weeks thereafter. If no weight concerns are noted at this point, weights will be measured monthly thereafter. Weights will be recorded in each unit's Weight Record chart or notebook and in the individual's medical record,</p> <p>During a review of the facility's P&P titled, Change in a Resident's Condition or Status last reviewed 1/3/2025, indicated, Our 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 Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status. Regardless of the resident's current mental or physical condition, a nurse or healthcare provider will inform the resident of any changes in his/her medical care or nursing treatment,</p>		

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<p>F 0641</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42275</p> <p>Based on interview and record review, the facility failed to accurately complete the Minimum Data Set (MDS - a resident assessment tool) Assessment Section K (Swallowing/Nutritional Status) dated 4/14/2025 under Section K0200 (the section for a resident weight) and Section K0300 (the section for weight loss) by failing to indicate the resident's body weight based on most recent measure in last 30 days which then led to an inaccurate assessment data entered under Section K0300 for one of four sampled residents (Resident 1).</p> <p>This deficient practice had the potential to negatively affect Resident 1's plan of care and delivery of services.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record, the Admission Record indicated the facility originally admitted the resident on 1/14/2025 and readmitted on [DATE] with diagnoses that included hypothyroidism (when the thyroid gland doesn't make enough thyroid hormones to meet your body needs), diabetes mellitus (DM - a condition that happens when your blood sugar is too high), hypertension (abnormally high blood pressure), and morbid (severe) obesity (a medical condition where someone has excessive fat accumulation that presents a risk to health).</p> <p>During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 4/14/2025, the MDS indicated Resident 1's cognition (mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was intact. The MDS further indicated that Resident 1 required maximum assistance from staff with lower body dressing and transfer, moderate assistance with bed mobility and toileting hygiene, and independent with eating.</p> <p>Further review of Resident 1's MDS for Section K indicated as follows:</p> <p>a. Under Section K0200 dated 1/17/2025 indicated Resident 1's weight was 309 pounds (lbs. - an abbreviation for pounds which is a unit of weight).</p> <p>b. Under Section K0200 dated 4/14/2025 indicated Resident 1's weight was 265 lbs.</p> <p>c. Under Section K0300 dated 4/14/2025 indicated zero (0) means no or unknown weight loss of five (5) percent (% - unit of measure) in the last month or weight loss of 10 % or more in the last 6 months.</p> <p>During a review of Resident 1's Weights and Vitals Summary dated 4/24/2025, the Weight Summary indicated Resident 1's weights as follows:</p> <p>a. A strikethrough entry (often called a strikeout, is a formatting style where a horizontal line is drawn to indicate that the entry or information has been deleted) dated 1/18/2025, timed at 2:31 p.m. indicated Resident 1 weighs 309 pounds (lbs. - an abbreviation for pounds which is a unit of weight) measured by bed scale (a specialized weighing device designed to weigh residents who are bedridden or unable to stand).</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>b. A strikethrough entry dated 1/30/2025, timed at 8:37 a.m. and 3:16 p.m. indicated Resident 1 weighs 265 lbs. measured by mechanical lift (a device used to assist in the movement and transfer of individuals who need help with mobility due to limitations in weight-bearing or movement ability).</p> <p>c. An entry dated 1/31/2025 timed at 9:12 a.m. entered by the Director of Nursing (DON) indicated declined order.</p> <p>During a review of Resident 1's General Acute Care Hospital 1 (GACH 1) discharge summary and orders for nursing home (discharge summary) dated 1/10/2025, the discharge summary indicated that Resident 1's weight was 309 lbs. on 1/8/2025.</p> <p>During a review of Resident 1's GACH 2 History and Physical (H&P) dated 4/5/2025, the H&P indicated that Resident 1's weight was 300 lbs.</p> <p>During a review of Resident 1's Nutrition/Dietary Progress Notes dated 4/24/2025 timed at 9:04 a.m., the Nutrition/Dietary Progress Note indicated Resident 1 had been refusing weights and that the last recorded weight obtained was in January. The Nutrition/Dietary Progress Note indicated to continue to encourage Resident 1 to allow facility staff to obtain weights for baseline assessment.</p> <p>During a concurrent interview and record review on 4/25/2025 at 3:40 p.m., with Minimum Data Set Nurse 1 (MDSN - a specialized nurse who collects and documents information about residents to help ensure they receive quality care, and that the facility is compliant with government regulations), MDSN 1 reviewed Resident 1's MDS Section K dated 1/17/2025 and 4/14/2025, and Weight Summary dated 4/24/2025. MDSN 1 stated that the 265 lbs. weight entered under Section K0200 dated 4/14/2025 was taken from the Weight Summary report dated 1/30/2025. When MDSN 1 was asked if the facility should utilize Resident 1's weight over 30 days from the Assessment Reference Date (ARD - the specific endpoint for the observation periods in the MDS assessment process), the MDSN 1 stated a resident's weight should be monitored every month at a minimum. MDSN 1 stated he was not aware that Resident 1 had been refusing to be weighed. MDSN 1 further stated that he (MDSN 1) should not have utilized Resident 1's weight of 265 lbs. obtained on 1/30/2025 and entered under Section K0200 as Resident 1's weight on 4/14/2025. MDSN 1 stated that when he (MDSN 1) entered no data available under Section K0200, MDSN 1 was unable to proceed with the MDS process, so he (MDSN 1) entered an inaccurate data of 265 lbs. MDSN 1 stated he reviewed Resident 1's GACH 1 clinical records dated 1/8/2025 (within 30 days from the ARD 1/17/2025) which showed a weight of 309 lbs. and Resident 1's GACH 2 clinical records dated 4/5/2025, which showed a weight of 300 lbs. MDSN 1 stated he got confused which then led to an inaccurate data entered under Section K0300 (weight loss) dated 4/14/2025. MDSN 1 stated he should have ensured the accuracy of the data entered and should have ensured accurate assessment of Resident 1's body weight in order to develop a specific plan of care as it relates to Resident 1's nutritional status.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Comprehensive Assessments last reviewed 1/3/2025, indicated, Comprehensive MDS assessments are conducted to assist in developing person-centered care plans. The facility conducts comprehensive, accurate, standardized, reproducible assessments of each resident's functional capacity using the Resident Assessment Instrument (RAI) specified by Centers for Medicare & Medicaid Services (CMS),</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility provided Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual dated October 2023, indicated, Section K for Swallowing/Nutritional Status; Steps for assessment for K0200 B Weight indicated, 'Base weight on the most recent measure in the last 30 days If a resident cannot be weighed, for example because of extreme pain, immobility, or risk of pathological fractures, use the standard no information code (-) and document rational on the resident's medical record.' And the definition of weight loss for K0300 indicated, 10% weight loss in 180 days: Start with the resident's weight closest to 180 days ago and multiply it by .90 (or 90%). The resulting figure represents a 10% loss from the weight 180 days ago. If the resident's current weight is equal to or less than the resulting figure, the resident has lost 10% or more body weight.'</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42275</p> <p>Based on interview and record review, the facility failed to develop a comprehensive person-centered care plan (a document designed to facilitate communication among members of the care team that summarizes a resident's health conditions, specific care needs, and current treatments) and implement care plan interventions for one of four sampled residents (Resident 1) to address Resident 1's refusal to allow body weight monitoring.</p> <p>These deficient practices had the potential to negatively affect the delivery of care and services and placed Resident 1 at risk for impaired nutrition and decline in well-being.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record, the Admission Record indicated the facility originally admitted the resident on 1/14/2025 and readmitted on [DATE] with diagnoses that included hypothyroidism (when the thyroid gland doesn't make enough thyroid hormones to meet your body needs), diabetes mellitus (DM - a condition that happens when your blood sugar is too high), hypertension (abnormally high blood pressure), and morbid (severe) obesity (a medical condition where someone has excessive fat accumulation that presents a risk to health).</p> <p>During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 4/14/2025, the MDS indicated Resident 1's cognition (mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was intact. The MDS further indicated that Resident 1 required maximum assistance from staff with lower body dressing and transfer, moderate assistance with bed mobility and toileting hygiene, and independent with eating.</p> <p>During a review of Resident 1's Order Summary Report, dated 1/14/2025, the Order Summary Report indicated to obtain weekly weights for four weeks one time a day every Wednesday for four weeks. Order Date 1/14/2025; Start Date 1/15/2025; and End Date 2/12/2025.</p> <p>During a review of Resident 1's Physician Order Summary, dated 4/9/2025, timed at 12:38 p.m. indicated to obtain weekly weights for four weeks. Order Date 4/9/2025.</p> <p>During a review of Resident 1's Weights and Vitals Summary dated 4/24/2025, the Weight Summary indicated Resident 1's weights as follows:</p> <p>a. A strikethrough entry (often called a strikeout, is a formatting style where a horizontal line is drawn to indicate that the entry or information has been deleted) dated 1/18/2025, timed at 2:31 p.m. indicated Resident 1 weighs 309 pounds (lbs. - an abbreviation for pounds which is a unit of weight) measured by bed scale (a specialized weighing device designed to weigh residents who are bedridden or unable to stand).</p> <p>b. A strikethrough entry dated 1/30/2025, timed at 8:37 a.m. and 3:16 p.m. indicated Resident 1 weighs 265 lbs. measured by mechanical lift (a device used to assist in the movement and transfer of individuals who need help with mobility due to limitations in weight-bearing or movement ability).</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>c. An entry dated 1/31/2025 timed at 9:12 a.m. entered by the Director of Nursing (DON) indicated declined order.</p> <p>During a review of Resident 1's Nutrition/Dietary Progress Notes dated 4/24/2025 timed at 9:04 a.m., the Nutrition/Dietary Progress Note indicated Resident 1 had been refusing weights and that the last recorded weight obtained was in January. The Nutrition/Dietary Progress Note indicated to continue to encourage Resident 1 to allow facility staff to obtain weights for baseline assessment.</p> <p>During a concurrent interview and record review on 4/24/2025 at 10:11 a.m., with RN 1, RN 1 reviewed Resident 1's progress notes and care plans (from Resident 1's original admitted [DATE] to 4/23/2025). RN 1 stated that RN 1 did not receive reports from any staff that Resident 1 had been refusing to be weighed. RN 1 stated she was unable to locate entries in Resident 1's progress notes and care plans (from 1/14/2025 to 4/23/2025) regarding Resident 1's refusal to be weighed. When RN 1 was asked what the facility protocol was for a resident refusing to be weighed, RN 1 stated that the facility should have notified the physician and should have developed a care plan to address Resident 1's refusal to allow body weight monitoring. RN 1 further stated there was no documented evidence found indicating Resident 1's physician was notified of Resident 1's refusal to allow body weight monitoring.</p> <p>During a concurrent interview and record review on 4/25/2025 at 2:55 p.m., with Licensed Vocational Nurse 1 (LVN 1), LVN 1 reviewed Resident 1's progress notes and care plans (from Resident 1's original admitted [DATE] to 4/23/2025). LVN 1 stated she was unable to locate care plans (from 1/14/2025 to 4/23/2025) regarding Resident 1's refusal to be weighed. LVN 1 stated that LVN 1 was unaware that Resident 1 had been refusing to be weighed because the resident's body weights were reported to the Director of Nursing (DON) directly. LVN 1 stated if a resident refused to have his or her weight checked three times in a row, the resident's physician should be notified and health education including the possible risk of not allowing for weight to be monitored should be provided to the resident. LVN 1 further stated a care plan should have been developed and interventions should have been implemented to address Resident 1's refusal and nutritional needs.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered last reviewed on 1/3/2025, indicated, A comprehensive, person-centered care plan that includes measurable objectives and the timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change,</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42275</p> <p>Based on interview and record review, the facility failed to conduct a nutritional assessment upon admission for one of four sampled residents (Resident 1), as per the facility's policy and procedure (P&P) titled, Nutritional Assessment.</p> <p>This deficient practice had the potential to place Resident 1 at risk for undetected nutritional status and at risk for medical complications related to impaired nutrition.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record, the Admission Record indicated the facility originally admitted the resident on 1/14/2025 and readmitted on [DATE] with diagnoses that included hypothyroidism (when the thyroid gland doesn't make enough thyroid hormones to meet your body needs), diabetes mellitus (DM - a condition that happens when your blood sugar is too high), hypertension (abnormally high blood pressure), and morbid (severe) obesity (a medical condition where someone has excessive fat accumulation that presents a risk to health).</p> <p>During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 4/14/2025, the MDS indicated Resident 1's cognition (mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was intact. The MDS further indicated that Resident 1 required maximum assistance from staff with lower body dressing and transfer, moderate assistance with bed mobility and toileting hygiene, and independent with eating.</p> <p>During a review of Resident 1's Order Summary Report, dated 1/14/2025, the Order Summary Report indicated to obtain weekly weights for four weeks one time a day every Wednesday for four weeks. Order Date 1/14/2025; Start Date 1/15/2025; and End Date 2/12/2025.</p> <p>During a review of Resident 1's Physician Order Summary, dated 4/9/2025, timed at 12:38 p.m. indicated to obtain weekly weights for four weeks. Order Date 4/9/2025.</p> <p>During a review of Resident 1's Weights and Vitals Summary dated 4/24/2025, the Weight Summary indicated Resident 1's weights as follows:</p> <p>a. A strikethrough entry (often called a strikeout, is a formatting style where a horizontal line is drawn to indicate that the entry or information has been deleted) dated 1/18/2025, timed at 2:31 p.m. indicated Resident 1 weighs 309 pounds (lbs. - an abbreviation for pounds which is a unit of weight) measured by bed scale (a specialized weighing device designed to weigh residents who are bedridden or unable to stand).</p> <p>b. A strikethrough entry dated 1/30/2025, timed at 8:37 a.m. and 3:16 p.m. indicated Resident 1 weighs 265 lbs. measured by mechanical lift (a device used to assist in the movement and transfer of individuals who need help with mobility due to limitations in weight-bearing or movement ability).</p> <p>c. An entry dated 1/31/2025 timed at 9:12 a.m. entered by the Director of Nursing (DON) indicated declined order.</p> <p>(continued on next page)</p>		

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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.			
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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1's General Acute Care Hospital 1 (GACH 1) discharge summary and orders for nursing home (discharge summary) dated 1/10/2025, the discharge summary indicated that Resident 1's weight was 309 lbs. on 1/8/2025.</p> <p>During a review of Resident 1's GACH 2 History and Physical (H&P) dated 4/5/2025, the H&P indicated that Resident 1's weight was 300 lbs.</p> <p>During a review of Resident 1's Nutrition assessment dated [DATE], the Nutrition Assessment was completed and signed by Registered Dietician 1 (RD 1) on 4/24/2025.</p> <p>During a review of Resident 1's Nutrition/Dietary Progress Notes dated 4/24/2025 timed at 9:04 a.m., the Nutrition/Dietary Progress Note indicated Resident 1 had been refusing weights and that the last recorded weight obtained was in January. The Nutrition/Dietary Progress Note indicated to continue to encourage Resident 1 to allow facility staff to obtain weights for baseline assessment.</p> <p>During a concurrent interview and record review on 4/25/2025 at 4:30 p.m., with the Director of Staff Development (DSD), the DSD reviewed Resident 1's Nutrition assessment dated [DATE]. The DSD stated he (DSD) was not able to find documented evidence indicating a Nutrition Assessment was completed by the dietician when Resident 1 was originally admitted on [DATE]. The DSD further stated that it is important to conduct an initial Nutrition Assessment because it serves as the baseline of Resident 1's nutritional status in order to identify any nutritional concerns and to implement interventions to address Resident 1's nutritional needs.</p> <p>During a phone interview on 4/25/2025 at 4:49 p.m., with RD 1, RD 1 stated that the initial Nutrition Assessment should have been conducted within 14 days from the date of the admission. RD 1 stated she (RD 1) was unable to recall why Resident 1's initial Nutrition Assessment was not completed upon Resident 1's admission on 1/14/2025. RD 1 stated that Resident 1 was admitted during the transitional phases with the previous RD who is no longer working at the facility. RD 1 stated she (RD 1) thought that Resident 1's initial Nutrition Assessment was already completed by the previous RD. RD 1 stated she then conducted Resident 1's Nutrition Assessment upon Resident 1 return from the hospital in the middle of April 2025. When RD 1 was asked if RD 1 was aware that Resident 1 had been refusing to be weighed since January 2025, the RD stated that she was not aware until recently (4/24/2025).</p> <p>During a review of the facility's P&P titled, Nutritional Assessment last reviewed 1/3/2025, indicated, As part of the comprehensive assessment, a nutritional assessment, including current nutritional status and risk factors for impaired nutrition, shall be conducted for each resident. The dietitian, in conjunction with the nursing staff and health care practitioners, will conduct a nutritional assessment for each resident upon admission (within current baseline assessment timeframes) and as indicated by a change in condition that places the resident at risk for impaired nutrition,</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42275</p> <p>Based on interview and record review, the facility failed to:</p> <ol style="list-style-type: none"> 1. Ensure that the on-coming nurse (Licensed Vocational Nurse 1 [LVN 1]) signed the Narcotic (a controlled medication or substance with a high potential for abuse that in moderate doses dulls the senses, affects mood or behavior, relieves pain and induces sleep) Count Sheet (NCS- a form used to account all controlled medications, and to transfer accountability from the out-going nurse to the on-coming nurse) on 4/24/2025 for 7 a.m. to 3 p.m. shift after counting the controlled medications with the out-going nurse (Licensed Vocational Nurse 2 [LVN 2]). 2. Ensure that the on-coming nurse (Licensed Vocational Nurse 3 [LVN 3]) signed the NCS on 4/9/2025, 11 p.m. to 7:00 a.m. shift in one of two inspected medication carts (MC 3) at the Nursing Station (NS). 3. Administer Levothyroxine Sodium (levothyroxine - a medication used to treat an underactive thyroid gland [a gland that makes and stores hormones that help regulate the heart rate, blood pressure, body temperature, growth development and energy]) scheduled to be given on 1/15/2025 at 6:30 a.m. in accordance with the physician's order for one of four sampled residents (Resident 1). <p>These deficient practices had the potential to result in unidentified controlled medication loss and increased the risk for drug diversion (transfer of a medication from a legal to an illegal use) and had the potential to result in unintended complications related to the management of hypothyroidism that includes fatigue (extreme tiredness resulting from mental or physical exertion or illness), weight gain, slow heart rate, and difficulty concentrating.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During a concurrent interview and record review on 4/24/2025 at 7:40 a.m., with LVN 1, the MC3 NCS for the month of April 2025 was reviewed. The MC3 NCS dated 4/24/2025 (7:00 a.m. to 3:00 p.m. shift) was blank. LVN 1 stated LVN 1 forgot to sign the NCS form after counting the controlled medications with the out-going nurse (LVN 2). LVN 1 then proceeded to sign the NCS form. LVN 1 stated that two nurses (on-coming nurse and out-going nurse) should sign together at the same time right after counting the controlled medications. 2. During a concurrent interview and record review on 4/24/2025 at 7:45 a.m., with LVN 1, the MC3 NCS for the month of April 2025 was reviewed. The MC3 NCS dated 4/9/2025 (11:00 p.m. to 7:00 a.m. shift) was blank indicating that it was not signed by the on-coming nurse (LVN 3). LVN 1 stated that LVN 1 was unable to determine if the controlled medications were counted together by two licensed nurses per the facility protocol on 4/9/2025 at 11:00 p.m. because the on-coming nurse did not sign on the NCS. <p>(continued on next page)</p>		

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<p>F 0755</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 4/24/2025 at 9:54 a.m., with the Director of Nursing (DON), the DON reviewed the MC3 NCS for the month of April 2025. The DON stated that she (DON) received the report from LVN 1 that LVN 1 did not sign on 4/24/2025 after counting with the night shift nurse. The DON stated that the facility protocol indicated for two licensed nurses (on-coming nurse and out-going nurse) to sign the NCS at the same time (right after counting the controlled medications) to prove that both licensed nurses confirmed the controlled medication amounts matched and to be able to identify if there was any discrepancy with the controlled medication count. The DON further stated that LVN 1 and LVN 3 should have signed right after the count because no documentation meant no count done.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Controlled Substances last reviewed on 1/3/2025, indicated, This facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications Nursing staff count controlled medication inventory at the end of each shift, using these records to reconcile the inventory count. The nurse coming on duty and the nurse going off duty make the count together and document and report any discrepancies to the director of nursing services,</p> <p>3. During a review of Resident 1's Admission Record, the Admission Record indicated the facility originally admitted the resident on 1/14/2025 and readmitted on [DATE] with diagnoses that included hypothyroidism (when the thyroid gland doesn't make enough thyroid hormones to meet your body needs), diabetes mellitus (DM - a condition that happens when your blood sugar is too high), hypertension (abnormally high blood pressure), and morbid (severe) obesity (a medical condition where someone has excessive fat accumulation that presents a risk to health).</p> <p>During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 4/14/2025, the MDS indicated Resident 1's cognition (mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was intact. The MDS further indicated that Resident 1 required maximum assistance from staff with lower body dressing and transfer, moderate assistance with bed mobility and toileting hygiene, and independent with eating.</p> <p>During a review of Resident 1's Order Summary Report, dated 1/14/2025, the Order Summary Report indicated levothyroxine 75 microgram (mcg - a unit of measurement); give one tablet by mouth in the morning for hypothyroidism.</p> <p>During a review of Resident 1's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) dated 1/15/2025, the MAR indicated to administer levothyroxine 75 mcg at 6:30 a.m. however Registered Nurse 2 (RN 2) documented 'Other'.</p> <p>During a review of Resident 1's Progress Notes; Type - Medication Administration Note, dated 1/15/2025, timed at 7:03 a.m., indicated Resident 1 was newly admitted and awaiting delivery of levothyroxine 75 mcg from the pharmacy.</p> <p>(continued on next page)</p>		

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<p>F 0755</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 4/24/2025 at 10:14 a.m. with the Director of Nursing (DON), the DON reviewed Resident 1's physician order for levothyroxine dated 1/14/2025 and Resident 1's MAR for levothyroxine dated 1/15/2025, with scheduled administration time of 6:30 a.m. The DON stated that levothyroxine was not administered to Resident 1 on 1/15/2025 at 6:30 a.m. because the medication (levothyroxine) was not yet delivered to the facility. The DON further stated there was no documented evidence found indicating levothyroxine was given to Resident 1 upon receipt. The DON stated there was no documented evidence found Resident 1's physician was notified about the missed levothyroxine dose on 1/15/2025.</p> <p>During a review of the facility's P&P titled, Administering Medications last reviewed on 1/3/2025, indicated, Medications are administered in a safe and timely manner, and as prescribed Medications are administered in accordance with prescribed orders, including any required time frame If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administrating the medication shall initial and circle the MAR space provided for that drug and dose,</p>		