STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056148	A. Building B. Wing	01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Casitas Care Center	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)
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. Based on interview and record review the facility failed to ensure that a 72-hour neurological check (neuro check- an assessment conducted to assess a person's brain and nervous system function by checking level of consciousness, behavior, pupils, movement, and vital signs to identify any changes in condition) was completed for one of three sampled residents (Resident 1) after Resident 1's unwitnessed fall on 12/18/2025. This deficient practice had the potential to result in delayed identification of changes in Resident 1's condition, which could affect the timely delivery of appropriate care and treatment.Findings: During review of Resident 1's admission Record, the admission Record indicated the facility admitted the resident on 12/3/2025 with diagnosis including type 2 diabetes (a condition that affects the way the body processes blood sugar), work together to provide structure, support, stability, and enable movement), abnormal posture, unspecified fall, and vascular dementia (a decline in thinking, memory, and reasoning caused by brain damage from impaired blood flow,, leading to problems with planning, judgment, and concentration, and symptoms that can appear suddenly or gradually). During a review of Resident 1's Minimum Data Set (MDS- a standardized assessment and screening tool) dated 12/8/2025, the MDS indicated Resident 1's cognition (a mental process of acquitting knowledge and understanding) was moderately impaired. Resident 1 required partial/moderate assistance with toileting hygiene, personal hygiene, and upper body dressing and required substantial/maximal assistance with lower body dressing. During a review of Resident 1's care plan date (CP) initiated on 12/5/2025, the CP indicated the resident is risk for falls with injury related to limited mobility, dementia, history of falls, unsteady gait (a person's manner of walking), and weakness. During a review of Resident 1's Change in Condition Evaluation (COC- the process of assessing, documenting, and responding to a significant unexpected change in a person's physical, mental, or functional health) dated 12/18/2025 timed at 1:55 p.m., the COC indicated Resident 1 had a fall and was found sitting on the floor. During an interview and concurrent record review on 1/9/2026 at 1:40 p.m. with the Infection Preventionist (IP), Resident 1's Neuro Check Flowsheets were reviewed. The IP stated that Resident 1 had an unwitnessed fall on 12/18/2025 and a 72-hour neuro check was initiated following the fall. The IP stated that Resident 1's 72-hour neuro check was initiated on 12/18/2025 but was not completed. The IP stated that 72-hour neuro check was not completed for the following: 12/18/2025 for every (Q) 30 minutes #2, Q 30 minutes #3, Q 30 minutes #4, Q30 minutes #5, Q 30 minutes #6; Q 1 hour #1, Q 1 hour #2, Q 1 hour #3, and Q 1 hour #4. The IP continued to state that the charge nurse responsible for the care of Resident 1 was responsible for assessing Resident 1 and completing the 72-hour neuro checks. The IP stated that completion of a 72-hour neuro check is important after an unwitnessed fall to ensure that the resident did not have changes in behavior or level of consciousness and that the physician is notified immediately if any changes in the resident's condition are noted. During a review of the facility's policy and procedure (P&P) titled Neurological Assessment (Routine), review date 1/5/2026, the P&P indicated routine neurological assessment is conducted to (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: 056148	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/12/2026
NAME OF PROVIDER OR SUPPLIER Casitas Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 10626 Balboa Blvd. Granada Hills, CA 91344	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	evaluate the resident for small changes overtime that may be indicative of neurological injury. Routine neurological exams include assessing: a. mental status and level of consciousness; b. pupillary response; c. motor strength; d. sensation; and e. gait. Under documentation. The following information should be recorded in the resident's medical record: 1. The date and time the procedure was performed; 2. The name and title of the individual(s) who performed the procedure. 3. All assessment data obtained during procedure. 4. How the resident tolerated the procedure. 5 If the resident refused the procedure, the reason(s) why and the intervention taken. 6. The signature and title of the person recording the data. During a review of the facility's P&P titled Charting and Documentation, reviewed 1/5/2026, the P&P indicated all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care.