

| | | | |
|--|--|--|--|
| 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 01/16/2026 |
| 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) | | |
| F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few | <p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to accurately measure the pressure ulcer/injuries (PU/Is - injury to skin and underlying tissue resulting from prolonged pressure on the skin) wound measurements for two of three sampled residents' (Resident 1 and Resident 2). This deficient practice had the potential to delay necessary treatments and services and to increase the residents' risk of further skin breakdown. Findings: a. During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 11/27/2025 with diagnoses including unstageable pressure ulcer unspecified site, osteomyelitis (infection of the bone that causes inflammation and pain), spina bifida (a birth defect where the spine doesn't close completely during early pregnancy, leaving the spinal cord and nerves exposed), and abnormal posture. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 12/2/2025, the MDS indicated Resident 1's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and senses) skills for daily decision making were intact. The MDS indicated that Resident 1 required maximal assistance from staff for toileting and personal hygiene, shower, upper and lower body dressing, and bed mobility (movement). The MDS further indicated that Resident 1 was at risk of developing PUs/Is and had one or more unhealed PUs/Is. During a review of Resident 1's Progress Notes dated 11/28/2025 timed at 11:22 a.m., the Progress Notes indicated that Resident 1 had an unstageable by depth (UTD - a serious, deep pressure ulcer covered by dead tissue that hides how deep the damage goes) pressure ulcer on the sacrococcyx (pertaining to both the sacrum [triangular bone located in the lower back] and coccyx [tailbone]) that was present on admission [DATE]. The Progress Notes indicated a wound size of 7.66 centimeter (cm - a unit of measurement) in length, 10.87 cm in width, 0 cm in depth, and 67.66 centimeter squared (sq. cm - unit of measurement) in area. During a review of Resident 1's Surgical Consult dated 12/4/2025, the Surgical Consult indicated wounds located at the sacrococcyx extending to bilateral (affecting both the left and right sides of the body) buttocks stage four (IV- full thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) PU/I. The Surgical Consult indicated a wound size of 11.5 cm in length, 15.0 cm in width, 2.5 cm in depth, and 172.50 sq. cm in area before performing bone tissue debridement (medical removal of dead, damaged, or infected tissue to improve the healing potential of the remaining healthy tissue). During a review of Resident 1's Order Summary Report, the Order Summary Report indicated an order for sacrococcyx extending to bilateral buttocks stage IV PU/I: Cleanse with wound cleanser, pat, dry apply Medi-honey (a specialized, sterilized, medical-grade honey) and calcium alginate (used to heavily draining wounds to promote wound healing) then cover with super absorbent dressing, ordered 12/8/2025. During a concurrent interview and record review on 1/15/2026 at 1:57 p.m., with Treatment Nurse 1 (TN 1), reviewed Resident 1's wound photo that indicated the wound measurements of 7.66 cm in length, 10.87 cm in width, 0 cm in depth, and 67.66 sq. cm, that was taken by TN 1 on 11/28/2025 and the wound</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 |
| FORM CMS-2567 (02/99) Previous Versions Obsolete | Event ID: | Facility ID: 056148 |
| | | If continuation sheet Page 1 of 3 |

| | | | |
|--|---|--|--|
| 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 01/16/2026 |
| 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 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>measurements indicated on the Progress Notes dated 11/28/2025. TN 1 stated that the photo taken by TN 1 indicated the wound depth was zero (0) cm, which was read automatically by the device when taking the photos. TN 1 further stated that she did not measure Resident 1's wound sizes manually on 11/28/2025, and the actual wound measurements were not done until 12/4/2025. When TN 1 was asked how TN 1 could tell the progress of the wound without the actual wound measurements, TN 1 stated they would know the wound progress by the photos taken for all wounds upon admission or at least on the following day then on a weekly basis. b. During a review of Resident 2's admission Record, the admission Record indicated the facility admitted Resident 2 on 12/29/2025 with diagnoses including acute kidney failure (when the kidneys suddenly stop effectively filtering waste and balancing fluids) and disorder of the skin and subcutaneous (under the layers of the skin) tissue. During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2's cognitive skills for daily decision making were severely impaired. The MDS indicated that Resident 2 required maximal assistance from staff for toileting hygiene, lower body dressing, sit to stand, and transfer. The MDS further indicated that Resident 2 was at risk of developing PUs/l's and had one or more unhealed PUs/l's. During a review of Resident 2's Progress Notes dated 12/30/2025 timed at 12:38 p.m., the Progress Notes indicated that Resident 2 had a sacral PU/l that was present on admission [DATE] and had a wound size 1.14 cm in length, 0.57 cm in width, 0 cm in depth, and 0.43 sq. cm in area. During a review of Resident 2's Surgical Consult dated 1/15/2026, the Surgical Consult indicated a wound on the coccyx extending to right and left buttock stage two (II) PU/l (partial-thickness loss of skin, presenting as a shallow open sore or wound). The Surgical Consult indicated a wound size of 7.0 cm in length, 3.0 cm in width, 0.1 cm in depth, and 21 sq. cm in area, and the wound progress was undetermined because it was the first visit. During a concurrent interview and record review on 1/15/2026 at 1:45 p.m., with TN 1, reviewed Resident 2's wound photo that indicated the measurements of 1.14 cm in length, 0.57 cm in width, 0 cm in depth, and 0.43 sq. cm in area taken by TN 1 on 12/30/2025 and the wound measurements indicated on the Surgical Consult Progress Notes dated 1/15/2026. TN 1 reviewed Resident 2's skin assessment done upon arrival, 12/29/2025, and stated that the admitting nurse marked the skin sites without measurements upon arrival on 12/29/2025. TN 1 stated TN 1 took photos and measured Resident 2's wounds on the following day, 12/30/2025, indicating a stage II PU/l. When TN 1 was asked how TN 1 measured Resident 2's PU/l on the sacral area on 12/30/2025 because the depth was zero (0) cm, TN 1 stated that she did not measure the wound size manually, and the wound measurements documented on the photo were measured automatically by the device when taking the photos. TN 1 stated TN 1 was aware that sometimes the measurements that were read automatically when taking wound pictures were not correct but stated she did not take the actual measurements because the treatment nurse and the wound consultant would measure the wound together when the wound consultant visits weekly. During a concurrent interview and record review on 1/16/2026 at 3:40 p.m., with the Director of nursing (DON), reviewed Resident 1 and 2's skin assessments and the photos taken by TN 1 of Resident 1 and Resident 2's wounds since their admissions. The DON stated that TN 1 took the photos but documented Resident 1 and 2's wound measurements incorrectly and did not measure the PU/l sizes manually to correct the wound sizes and depths that were read automatically by the devices when taking the photos. The DON stated that it was important to measure and document the wound sizes correctly, otherwise, there would be confusion with wound healing progress, and could not tell if the wounds were improving or worsening without the wound measurements measured correctly. During a review of the facility's policy and procedure (P&P) titled, Pressure Ulcer/Injury Risk Assessment, last reviewed on 1/5/2026, the P&P indicated, Steps in the Procedure: Gather assessment tools and documentation and conduct the assessment</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 01/16/2026 |
| 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 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>in the manner most appropriate to the resident's condition and willingness to participate. Conduct a structured pressure ulcer/injury risk assessment using a facility-approved tool. Documentation: The condition of the resident's skin (i.e., the size and location of any red or tender areas). During a review of the facility's P&P titled, Charting and Documentation, last reviewed on 1/5/2026, the P&P indicated, Documentation in the medical record will be objective (not optional or speculative), complete, and accurate.</p> | | |