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	03/26/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facilityˆfailed to: 1. Maintain a comfortable sound levels to promote a restful environment for two of three residents (Resident 3 and 89) investigated under the care area Safe/Clean/Homelike Environment. This deficient practiceˆresulted in the residents feeling disrespected, annoyed and awaken unnecessarily. 2. Provide a safe, clean, comfortable,ˆand homelike environment forˆone of three sampledˆresidentsˆ(Residentˆ91)ˆwhen there was dust buildup on the base of the resident's facility provided fan and wall.ˆˆ This deficient practiceˆdeniedˆResident 91ˆthe right to aˆclean, comfortable,ˆandˆhomelikeˆenvironment andˆhad the potential toˆnegativelyˆimpactˆResident 91'sˆquality ofˆlife.ˆ Findings:ˆ 1.a. During a review of Resident 3's admission Record (AR), the AR indicated the facility admitted the resident on 2/28/2025 with diagnosis including heart failure (heart muscle is weakened or stiffened, failing to keep up with the body's blood demand) and obstructive sleep apnea (a common disorder where breathing repeatedly stops and starts during sleep due to throat muscles relaxing and blocking the airway). During a review of Resident 3's Minimum Data Set (MDS-a standardized assessment and care screening tool) dated 11/27/2025, the MDS indicated the resident had the ability to make self-understood and the ability to understand others. The MDS indicated that Resident 3 required partial/moderate assistance (helper does more than half the effort) upper body dressing, lower body dressing, putting on/taking off footwear, personal hygiene and substantial/maximal assistance (helper does more than half the effort) with toileting shower hygiene. During an interview on 03/23/2026 at 11:38 a.m. in Resident 3`s room, Resident 3 stated that there is this one Certified Nurse Assistant that is very loud when she talks and he would get startled when she goes in the room because of her loud voice and staff should tone down their voices because it disturbs us when we are resting.ˆ ˆ 1.b.During a review of Resident 89's admission Record (AR), the AR indicated the facility admitted the resident on 1/21/2026 with diagnosis including, alcohol dependence (alcohol addiction) and depression (a common, serious mood disorder characterized by persistent sadness, loss of interest in activities, and low energy). During a review of Resident 89's MDS dated [DATE], the MDS indicated the resident had the ability to make self-understood and the ability to understand others. The MDS indicated that Resident 89 required partial/moderate assistance (helper does less than half the effort) with oral hygiene, (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
	056148	A. Building B. Wing	03/26/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	toileting hygiene, shower, upper body dressing, lower body dressing, putting on/taking off footwear, and personal hygiene and substantial/maximal assistance (helper does more than half the effort) with toileting hygiene, shower, upper body dressing, lower body dressing and personal hygiene. During a Resident Council group interview on 03/24/2026 at 1:30 p.m., Resident 89 (one of the participants) stated that sometimes early in the morning around 6 a.m. to 7 a.m. the noise in the hallway near the nurses` station is very loud. Resident 89 stated that they sometimes play loud music and we can hear their conversation which sometimes awaken us and its difficult for him to go back to sleep. During an interview and record review on 03/26/2026 at 1:58 p.m., with the Director of Staff Development (DSD), the DSD stated that he is aware of the complaint of some residents about a specific staff that is very loud. The DSD stated that this facility is their home (residents) and should be restful and homelike. The DSD stated that the noise level should be comfortable for the residents and must not interrupt their sleeping time especially in the early morning. The DSD stated that he had providedˆin-service to the staff regarding maintaining a comfortable noise level. Upon review of the In-Service Training Minutes for Noise Level dated 1/8/2026 with the DSD, the In-Service training did not include the specific staff that was mentioned by the residents. During an interview on 3/26/2026 at 2:04 p.m. with Certified Nurse Assistant 1 (CNA 1), CNA1 stated that she is aware that she is loud and needs to tone down her voice so as not to disturb the residents especially if they are sleeping. CNA 1 stated it is disrespectful if we are loud in the facility and makes the environment not homelike. During a review of the facility`s policy and procedures (PP) titled, Homelike Environment, last reviewed on 1/5/2026, the PP indicated that Residents are provided with a safe, clean, comfortable and homelike environment.the facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include clean, sanitary and orderly environment, comfortable sound levels. 2. Duringˆaˆreview ofˆResident 91'sˆadmission Record, theˆadmission Recordˆindicatedˆtheˆfacility admitted theˆresidentˆˆonˆ10/17/2025ˆwith diagnoses including, but not limited to,ˆfracture of the left humerus (broken left arm)ˆandˆidiopathic peripheral autonomic neuropathy (aˆconditionˆwhere the nerves outside of the brain and spinal cord areˆdamaged for an unknown reason).ˆ ˆˆ During a review ofˆResident 91's MDS, dated [DATE],ˆthe MDS indicated the residentˆwas cognitively intactˆ(able to think, learn, and remember clearly). The MDS indicatedˆResident 91ˆrequiredˆsubstantialˆassistanceˆ(helper does more than half of the effort)ˆforˆshowering, lower body dressing, and putting on and taking off footwear. The MDS indicated Resident 91ˆrequiredˆmoderateˆassistanceˆ(helper does less than half of the effort)ˆwith toileting, upper body dressing, and personal hygiene.ˆThe MDS indicated Residentˆ91ˆrequiredˆset up or cleaningˆassistanceˆ(helper sets up or cleans up; resident completes activity)ˆwith eating and oral hygiene.ˆ ˆ During an observation on 3/23/2026 at 12:44 p.m. at Resident 91's bedside,ˆthe resident's fan on the (continued on next page)

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	03/26/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	floor in front of her bed had a thick layer of dust build up on the base. The wall behind the fan had dustˆon top of theˆcoverˆmounted to the wallˆwhichˆcontainedˆcordsˆconnected to the resident's television.ˆ ˆ During a concurrent observation and interview on 3/25/2026 at 10:56 a.m.ˆwith the Maintenance Supervisor (MS) at Resident 91's bedside,ˆtheˆMSˆobservedˆand validatedˆthe dust build up on the resident'sˆfan and cord covering along the wall.ˆTheˆMSˆstatedˆthe facility provided this fan for the resident and it came from theˆfacility'sˆstorage.ˆTheˆMSˆstatedˆthere should not be dust in the observed areas and they should have been cleaned.ˆTheˆMSˆstatedˆhe was the supervisor for both the maintenance and housekeeping departments.ˆTheˆMSˆstatedˆhousekeeping should be cleaning these areas as a part of their regular duties.ˆTheˆMSˆstatedˆthey shouldˆbe dusted so they provide a clean area for the resident.ˆTheˆMSˆstatedˆthe dust could affect the air quality in the resident's room.ˆ ˆ During aˆreview of the facility's P&Pˆtitled, Homelike Environment,ˆlast reviewedˆ1/5/2026, the P&Pˆindicatedˆresidents are provided with a safe, clean,ˆcomfortableˆand homelike environment. The P&P furtherˆindicatedˆthe facilityˆstaffˆand management maximizes, to theˆextent possible,ˆthe characteristics of the facility that reflect aˆpersonalized, homelike setting including a clean, sanitary, and orderly environment.

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	03/26/2026

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 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 2) was free from unnecessary (any medication in excessive dose, excessive duration, without adequate monitoring) use of psychotropic drug (any medication capable of affecting the mind, emotions, and behavior) in accordance with the facility policy and procedure by failing to ensure Resident 2 did not have duplicate (more than one [1]) medication treatments with the use of quetiapine (antipsychotic [medication used to treat mental illness]) and clonazepam (a psychotropic drug used for agitation and as anxiolytic [reduce anxiety]) between 12/23/2025 and 3/24/2026. This deficient practice had the potential to place Resident 2 at risk for significant adverse consequences (unwanted, uncomfortable, or dangerous effects that a drug may have) such as drowsiness, dizziness and respiratory depression (stoppage of breathing) from the use of unnecessary psychotropic and antipsychotic drugs, which could result to impairment or decline in the residents' mental, physical condition, functional, and psychosocial status. Findings: During a review of Resident 2's admission Record (a document containing demographic and diagnostic information,) dated 3/24/2026, the admission Record indicated Resident 2 was admitted to the facility on [DATE] with a diagnosis including psychotic disorder (a mental health condition that causes a person to lose touch with reality, making it hard for them to distinguish what is real from what is imagined,) depression and anxiety. During a review of Resident 2's Minimum Data Set (MDS - a comprehensive resident assessment tool), dated 3/16/2026, the MDS indicated Resident 2 was severely impaired with cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS was marked for diagnoses including depression, anxiety and psychotic disorder and indicated Resident 2 received antipsychotics on a routine basis. During a review of Resident 2's Medication Administration Record (MAR - a record of medications administered to residents), for March 2026, the MAR indicated Resident 2 was prescribed the following: -clonazepam 0.5 milligram (mg - a unit of measure of mass) to give 0.5 tablet (0.25 mg) by mouth at bedtime for manifested by combative behavior and kicking staff, starting 3/8/2025 -monitor for anxiety manifested by combative behavior, kicking staff every shift -quetiapine 25 mg to give half tablet (12.5 mg) by mouth every 12 hours for manifested by agitation, starting 12/23/2025. -monitor behaviors(s) of agitation manifested by kicking every shift for use of quetiapine use, every shift for continues kicking. During a concurrent document review and interview on 3/24/2026 at 2:12 p.m., with Licensed Vocational Nurse 3 (LVN 3), LVN 3 reviewed Resident 2's MAR for March 2026. LVN 3 stated Resident 2's MAR indicated clonazepam was prescribed for combative behavior and kicking staff and quetiapine was also prescribed for kicking staff, and to monitor combative behavior and kicking staff for clonazepam use and to monitor kicking staff for quetiapine use. LVN 3 stated the addition of quetiapine order on 12/23/2025 did not have a specific indication or behavior that was different than the use for the clonazepam order. LVN 3 stated, as a result, the physician will not be able to make an accurate assessment of the effectiveness of clonazepam or quetiapine, as both were used and monitored for the same indication. LVN 3 stated that duplicate indications and monitoring for clonazepam and quetiapine lead to unnecessary psychotropic medication use and increased Resident 2's risk of experiencing additive adverse effects, such as drowsiness, dizziness, confusion, impaired coordination and respiratory depression. During an interview on 3/24/2026 at 2:54 p.m., with LVN 1, LVN 1 stated psychotropic and antipsychotic medications require a specific indication for behaviors unique for each medication prescribed, to allow for accurate assessment of the medication's effectiveness. LVN 1 stated the clonazepam and quetiapine orders for Resident 2 were both prescribed and monitored for the same indication resulting in duplication. During a concurrent record review and interview on 3/24/2026 at 3:07 p.m., with the Director of Nursing (DON), the DON reviewed (continued on next page)

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	03/26/2026

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	March 2026 MAR for Resident 2. The DON acknowledged the MAR indicated clonazepam was prescribed for combative behavior and kicking staff and quetiapine was prescribed for kicking staff. The DON also acknowledged clonazepam was monitored for combative behavior and kicking staff and there was no documentation for behaviors noted in March 2026, and quetiapine was monitored for kicking staff and the MAR indicated behaviors documented on 3/9/2026 and 3/10/2026. The DON added due to lack of having clear and specific indications and target behaviors identified and monitored for clonazepam and quetiapine, created a confusion amongst licensed nurses for appropriately documenting the behaviors. The DON added that this failure caused duplicate therapy for Resident 2, creating the potential for the resident to experience additive adverse medication effects and causing the physician to make inaccurate assessments of the specific medication's effectiveness, which could result in unnecessary dose increases.ˆ During a review of the facility's Policies & Procedures (P&P) titled, Psychotropic Medication Use, last reviewed 1/5/2026, the P&P indicated: A psychotropic drug is any medication that affects brain activity associated with mental processes and behavior, which includes but is not limited to antipsychotics, anxiolytics, hypnotics and antidepressants. The Facility should comply with the State Operations Manual, and all other Applicable Laws relating to the use of psychoactive medications. Psychotropic medications to treat behaviors will be used appropriately to address specific underlying mediation or psychiatric causes of behavioral symptoms. During a review of the facility's P&P titled Antipsychotic Medication Use, last reviewed 1/5/2026, the P&P indicated: An antipsychotic medication should be used only for conditions/diagnoses as documented in the record and as meets the definition(s) in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Training Revision (DSM-IV TR) or subsequent editions. In addition, before initiating or increasing an antipsychotic medication for enduring conditions, the target behavior must be clearly and specifically identified and monitored objectively and qualitatively.

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	03/26/2026

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 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 on observation, interview, and record review the facility failed to: 1.Reconcile (the process of comparing transactions and activity to supporting documentation) four (4) medication emergency kits (eKIT - kit containing medications needed to be used during emergencies) containing Controlled Substance-[CS, medications which have a potential for abuse and may also lead to physical or psychological dependence, also known as narcotics or Controlled Medication, CM]) for March 2026, in one (1) of one (1) inspected Medication Rooms (Medication room [ROOM NUMBER].) 2.Reconcile two (2) medication eKITs containing CS for March 2026, in two (2) of three (3) inspected Medication Carts (Medication Cart 1 Station 1, Medication Cart AM Station.) 3. Replace one (1) open used medication eKIT within 72 hours of opening the kit on 3/19/2026, in one (1) of one (1) inspected Medication Rooms (Medication room [ROOM NUMBER].) 4. Account for one (1) dose of CS for Resident 85 in one (1) of three (3) inspected medication carts (Medication Cart AM Station 2.) As a result, control and accountability of CSs and replacement of eKITs did not follow state and federal regulations and facility policy and procedures. These deficient practices increased the opportunity for CS diversion (the transfer of a controlled medication or other medication from a lawful to an unlawful channel of distribution or use,) and increased the risk that residents in the facility could have accidental exposure to harmful medications and delayed medication treatment during emergencies possibly leading to physical and psychosocial harm, hospitalization and death. In addition, Resident 85 could have accidental overdose (administration of more than the prescribed dose) to CS leading to their health and well-being to be negatively impacted. Findings: During an observation on 3/23/2026 at 12:40 p.m., with Registered Nurse (RN) 1 and the Director of Nursing (DON), in Medication room [ROOM NUMBER], there was: 1.One (1) open medication eKIT containing antibiotics (medications that are used to treat infections) and intravenous (medications given through the vein) medications with a document indicating the eKIT was opened on 3/19/2026 at 1:30 p.m. 2. Two (2) medication eKITs containing CSs stored in the refrigerator and labeled REF455 and REF587, without an accountability log for the reconciliation of CS inventory at every shift change for March 2026. 3. Two (2) medication eKITs containing CSs stored at room temperature in the cabinet and labeled PO656 and PO738, without an accountability log for the reconciliation of CS inventory at every shift change for March 2026. During a concurrent interview with RN 1 and the DON, RN 1 and the DON acknowledged the antibiotic and intravenous medication eKIT was open, used, contained documents indicating the kit was opened on 3/19/2026 and was awaiting replacement for a new one from pharmacy.ˆ The DON stated the eKIT should have been replaced with a new one from pharmacy within 72 hours of opening the eKIT.ˆ RN 1 and the DON acknowledged the eKIT was not replaced within 72 hours of opening.ˆ The DON statedˆthe facility was not compliant.ˆ The DON stated the facility failed to replace the medication eKIT with a new one within 72 hours of opening the eKIT and this failure could increase the risk of not having critical medications available for residents during emergencies leading to negative consequences causing resident harm, potential hospitalization and delay in medication treatment.ˆ ˆ During the interview, RN 1 stated that all CSs, including medication eKITs containing CSs should be reconciled at every shift.ˆ RNˆ1 stated the eKITs labeled above in the refrigerator and cabinet containing CSs in Medication room [ROOM NUMBER] was not reconciled at every shift in March 2026, and it was important to account for all CSs to ensure accountability and prevent Cs diversion.ˆ ˆ During an observation on 3/23/2026 at 1:08 p.m., with Licensed Vocational Nurse (LVN) 3, in Medication Cart 1 Station 1, there was one (1) medication eKIT containing CSs stored at room temperature and labeled 552, without an accountability log for the reconciliation of CS inventory at every shift change for March 2026. During a concurrent interview, LVN 3 stated that all CSs, including medication eKITs containing CSs should be reconciled at every shift.ˆ LVN 3 stated the eKIT labeled 552 in Medication Cart 1 Station 1 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
	056148	A. Building B. Wing	03/26/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reconciled at every shift in March 2026, and it was important to account for all CSs to ensure accountability and prevent CS diversion.ˆ During an observation on 3/23/2026 at 1:42 p.m., with Licensed Vocational Nurse (LVN) 2, in Medication Cart AM Station 1, there was: 1.One (1) medication eKIT containing CSs stored at room temperature and labeled 355, without an accountability log for the reconciliation of CS inventory at every shift change for March 2026. 2. a discrepancy in the count between the Antibiotic or Controlled Drug Record 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) for Resident 85. One (1) dose of diazepam (a CS used for feelings of panic) tablet was missing from the bubble pack compared to the count indicated on the Antibiotic or Controlled Drug Record accountability log for Resident 85.ˆ The Antibiotic or Controlled Drug Record accountability log for diazepam indicated the bubble pack should have contained a total of 9 diazepam 5 milligram)[mg]- a unit of measure of mass) tablets, after the last administration of diazepam 5 mg tablet documented/signed-off on 3/22/2026 at 5 p.m., however the medication bubble pack contained 8 diazepam 5 mg tablets and contained no other documentation of subsequent administrations. During a review of Resident 85's Medication Administration Record ([MAR - record of medications administered to a resident) for March 2026, the MAR indicated Resident 85 was prescribed diazepam five (5) mg orally twice a day for panicky feelings, to be given at 9 a.m. and 5 p.m. During a concurrent interview, LVN 2 stated LVN 2 administered one (1) diazepam 5 mg tablet to Resident 85 at 9 a.m., that morning (3/23/2026), and forgot to sign the Antibiotic or Controlled Drug Record accountability log. LVN 2 stated LVN 2 failed to follow the facility's policy of signing each CM dose on the Antibiotic or Controlled Drug Record accountability log after preparing the dose for the resident. LVN 2 stated LVN 2 understood it was important to sign each dose once administered to ensure accountability, prevention of CM diversion, and accidental exposures of harmful substances to residents. LVN 2 stated if documentation was not accurate then it can lead to medication error if overdosed leading to stoppage of breathing, hospitalization and possibly death for Resident 85. During the same interview, LVN 2 stated that all CSs, including medication eKITs containing CSs should be reconciled at every shift. LVN 2 stated the eKIT labeled 355 containing CSs in Medication Cart AM Station 2 was not reconciled at every shift in March 2026, and it was important to account for all CSs to ensure accountability and prevent CS diversion. During an interview, on 3/24/2026 at 3:15 p.m., with the DON, the DON stated medication eKITs containing CSs need to be counted and reconciled at every shift change to ensure accountability and prevent CS diversion.ˆ The DON acknowledged the eKITs labeled 355, 552, REF455, REF587, PO656M and PO738, did not have accountability logs and were not reconciled at every shift in March 2026. The DON stated that the facility will immediately implement an accountability log for reconciliation of eKits containing CSs. During the same interview, the DON stated that LVN 2 failed to follow facility policy of documenting the preparation of CM immediately on the Antibiotic or Controlled Drug Record accountability log for Resident 85. The DON stated not documenting the Antibiotic or Controlled Drug Record timely can lead to accountability failures, CM diversion, inaccurate clinical records, and accidental use and overdose of harmful substances for residents. During a review of the facility's Policy and Procedures (P&P) titled Controlled Medications, last reviewed 1/5/2026, the P&P indicated: C. When a CM is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record and the MAR: 1) date and time of administration 2) amount administered. 3) Signature of the nurse administering the dose on the accountability record at the time the medication is removed from the supply. During a review of the facility's P&P, titled Controlled Medication Storage, last reviewed 1/5/2026, the P&P indicated: Medications included in the Drug Enforcement Administration (DEA) classification as controlled substance are subject to special handling, storage, disposal and record keeping in the facility in accordance with federal, state and other applicable laws and regulations. a.The DON and the consultant pharmacist maintain facility's compliance with federal and state laws and regulations in the handling of controlled medications. d. 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
	056148	A. Building B. Wing	03/26/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	each shift change, a physical inventory of all controlled medications, including the emergency supply is conducted by two licensed nurses and is documented on the controlled medication accountability record. During a review of the facility's P&P titled Emergency Pharmacy Services/Emergency Kits, last reviewed 1/5/2026, the P&P indicated: An emergency supply of medications including emergency drugs, antibiotics, CSs,.is supplied by the provider pharmacy in limited quantities in portable, sealed containers that are in compliance with applicable state regulations. N. If exchanging kits, the used sealed kits are replaced with the new sealed kits within 72 hours of opening.

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	03/26/2026

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that its medication error rate was less than five (5) percent (%). Two (2) medication errors out of 25 total opportunities contributed to an overall medication error rate of 8% affecting two (2) of four (4) residents observed for medication administration (Resident 18 and 57.) The medication errors were as follows:1. Resident 18 did not receive a form of aspirin (a medication used for cerebrovascular accident [CVA - an interruption in the flow of blood to cells in the brain, mainly caused by hypertension (high blood pressure)] prophylaxis [PPX - prevention]) as ordered by Resident 18's physician. 2. Resident 57 did not receive a form of aspirin as ordered by Resident 57's physician. These failures had the potential to result in Resident 18 and 57 to experience medication adverse effects (unwanted, uncomfortable, or dangerous effects that a medication may have) and the potential to result in Residents 18's and 57's health and well-being to be negatively impacted. Findings: During an observation on 3/23/2026 at 9:10 a.m., in Medication Cart 1, Licensed Vocational Nurse (LVN) 3 was observed administering aspirin 81 milligram ([mg]-a unit of measure of mass) chewable tablet to Resident 57. Resident 57 was observed swallowing the aspirin tablet with glass of water. During an interview on 3/23/2026 at 2:04 p.m., with LVN 3, LVN 3 stated that LVN 3 administered aspirin 81 mg chewable tablet during the morning medication administration at 9:10 a.m. to Resident 57. LVN 3 stated that LVN 3 failed to follow the physician orders to administer aspirin 81 mg enteric coated ([EC] - a form of aspirin that is designed to slowly release medication) tablet. ˆLVN 3 stated EC tablets release slowly in the stomach and chewable tablets release immediately into the stomach. LVN 3 stated administering chewable tablet was considered a medication error because it was the wrong form of the medications.ˆ LVN 3 stated administration of aspirin 81 mg chewable tablet increased the risk of stomach irritation to Resident 57. During an observation on 3/23/2026 at 9:25 a.m., in Medication Cart 1, LVN 6 observed administering aspirin 81 mg chewable tablet to Resident 18. Resident 18 was observed swallowing the aspirin tablet with glass of water. During an interview on 3/23/2026 at 2:08 p.m., with LVN 6, LVN 6 stated that LVN 6 administered aspirin 81 mg chewable tablet during the morning medication administration at 9:25 a.m. to Resident 18. LVN 6 stated that LVN 6 failed to follow the physician orders to administer aspirin 81 mg EC tablet. ˆLVN 6 stated EC tablets release slowly in the stomach and chewable tablets release immediately into the stomach. LVN 6 stated administering chewable tablet was considered a medication error because it was the wrong form of the medications.ˆ LVN 6 stated administration of aspirin 81 mg chewable tablet increased the risk of stomach irritation to Resident 18. During an interview on 3/24/2026 at 3:15 p.m., with the Director of Nursing (DON), the DON stated that LVN 3 and 6 failed to administer aspirin 81 mg EC tablet to Resident 18 and 57, according to the physician orders. The DON stated that licensed nurses should follow facility medication administration guidelines to ensure physician orders are followed and the right medications are administered to residents. The DON stated Resident 18 and 57 may be at risk for developing stomach irritation from receiving aspirin 81 mg chewable tablet, and that the administration of chewable tablet was considered a medication error. During a review of Resident 18's admission Record (a document containing demographic and diagnostic information,) dated 3/23/2026, indicated the resident was originally admitted to the facility on [DATE] with diagnoses including hypertension. During a review of Resident 18's Order Summary Report, dated 3/23/2026, the Order Summary Report indicated Resident 18 was prescribed aspirin EC 81 mg once a day for CVA PPX, starting 2/18/2026. During a review of Resident 18's Medication Administration Record ([MAR] - a record of mediations administered to residents), for March 2026, the MAR indicated Resident 18 was prescribed aspirin EC 81 mg one (1) tablet once a day orally for CVA PPX, to be given at 9 a.m. During a review of Resident 57's admission Record dated 3/23/2026, indicated the resident was originally admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses including hypertension. (continued on next page)

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	03/26/2026

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 57's Order Summary Report, dated 3/23/2026, indicated Resident 57 was prescribed aspirin 81 mg EC tablet once a day for CVA PPX, starting 9/29/2025. During a review of Resident 57's MAR for March 2026, the MAR indicated Resident 57 was prescribed aspirin EC 81 mg one (1) tablet once a day orally for CVA PPX, to be given at 9 a.m. During a review of the facility's policy and procedures (P&P), titled Administering Medications, last reviewed 1/5/2026, the P&P indicated Medications are administered in a safe and timely manner, and as prescribed. 4. Medications are administered in accordance with prescriber orders, including any required time frame. 7. The individual administering the medication must check the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. During a review of the facility's P&P titled Medication Administration - General Guidelines, last reviewed 1/5/2026, the P&P indicated Medications are administered as prescribed. 2. Medications are administered in accordance with written orders of the attending physician. During a review of the facility's P&P titled Procedures for All Medications, last reviewed 1/5/2026, the P&P indicated: To administer medications in a safe and effective manner. F. Read medication label before administering. During a review of the facility's P&P titled Adverse consequences and Medication Errors, last reviewed 1/5/2026, the P&P indicated: 2. An ?adverse consequence' is defined as an unpleasant symptom or event that is due to or associated with a medication, such as an impairment or decline in an individual's mental or physical condition or functional or psychosocial status. An adverse consequence may include: a. Adverse drug/medication reaction; b. Side effect; 4. The staff and practitioner shall strive to minimize adverse consequences by: a. Following relevant clinical guidelines and manufacturer's specifications for use, dose, administration, duration, and monitoring of the medication; 3. A medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services. 4. Examples of medications errors include: e. wrong dosage form.

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	03/26/2026

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 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. Based on observation, interview, and record review the facility failed to store medications in accordance with manufacturer specifications, professional principles and facility policy and procedures by failing to ensure eye drops were stored separately from orally administered medications, in one (1) of three (3) inspected Medication Carts (Medication Cart 1 Station 1.) ˆ This deficient practice increased the risk of contamination of medications and receiving medications via the wrong route (internal versus external routes,) for residents in the facility, possibly leading to adverse health consequences resulting in the negative impact to their health and well-being. Findings: During a concurrent observation and interview on 3/23/2026 at 1:08 p.m., in Medication Cart 1 Station 1, with Licensed Vocational Nurse 3 (LVN 3), the following medications were stored in a manner contrary to the facility's P&P: -One (1) artificial tears (a medication used for dry eyes) eye drop bottle and one (1) atropine (a medication used to dilate the pupils of the eye)ˆeye drop bottle was stored with several oral medication bottles (including docusate [stool softener], acetaminophen [pain medication], vitamin b complex [supplement], lactobacillus [probiotic], oyster shell calcium [supplement], glucosamine [joint support] in the same bin/container of the medication cart. LVN 3 stated that eye drops should be stored separately from oral medications, to prevent errors in wrong route administration and possible infections/contaminations. LVN 3 acknowledged one (1) medication bin/container contained one (1) artificial tear eye drop bottle and one (1) atropine eye drop bottle with several orally administered medication bottles. LVN 3 stated the facility failed to store eye drops separate from oral medications. During an interview, on 3/24/2026 at 3:15 p.m., with the Director of Nursing (DON,) the DON stated internally (such as oral) and externally (such as eyes, ears, nose, skin) administered medications should be stored separately to prevent wrong route administration, infections and contaminations. The DON stated the facility failed to store the artificial tears and atropine eye drop bottles in Medication Cart 1 Station 1 separate from several orally administered medication bottles. During a review of facility's P&P titled, Storage of Medications, last reviewed on 1/5/2026, the P&P indicated Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. C. Orally administered medications are kept separate from externally used medications.

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	03/26/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview and record review, the facility failed to provide care in a manner that maintained a resident`s dignity and respect by failing to ensure a staff member knocked prior to entering a resident`s room for one ofˆtwoˆresidents (Resident 26) observed duringˆdining observation.ˆˆ This deficient practice violated the resident's right to be treated with respect and dignity and had the potential to affect Resident 26`s sense of self-worth and self-esteem.ˆ Findings:ˆ During a review of Resident 26's admission Record (AR), the AR indicated the facility admitted the resident on 3/31/2020ˆwith diagnosis including,ˆmajor depressive disorder (a serious mental health condition characterized by persistent, severe sadness, loss of interest, and low energy lasting at least two weeks) and hypertension (high blood pressure). During a review of Resident 26's Minimum Data Set (MDS-a standardized assessment and care screening tool) datedˆ3/02/2026, the MDS indicated Resident 26 had the ability to understand others and be understood and requiredˆsupervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with toileting hygiene, showers, lower body dressing and setup or clean-up assistance (helper sets up or cleans up; resident completes activity) with eating, oral hygiene, upper body dressing, putting on and taking off footwear and personal hygiene. During a concurrent observation and interview on 3/28/2026 at 12:15 p.m. with Certified Nurse Assistant 1 (CNA 1) outside of the main dining room, CNA1 was observed receiving a finished meal tray, from a staff member, containing a cup of ice cream and a crumpled plastic shrink wrap. CNA1 disposed of these items in the trash bin without wearing gloves and did not sanitize her hands after completing the task. CNA 1 then proceeded to wheel an open meal cart with three new meal trays and a container of food containing an unidentified soup. As CNA 1 was wheeling the meal cart, staff were observed taking out the trays from the meal cart. When CNA 1 reached the room of Resident 26, she then took out the container of food with an unidentified soup with her bare hands and entered the resident`s room without knocking and delivered the food container and placed them in the overbed table and removed the lid. When interviewed, CNA 1 stated that she should have performed hand hygiene by washing her hands or use a hand sanitizer after discarding items from a dirty tray and before delivering the food to Resident 26. CNA 1 stated that hand hygiene (washing, sanitizing) is important before touching meal trays to prevent infection and cross contamination among residents and staff. CNA 1 stated that she should have knocked on the resident`s door and asked permission to go in as a sign of respect for their right to privacy. During a review of the facility`s policy and procedure titled Dignity, last reviewed on 1/05/2026, the policy indicated that Each resident shall be cared forˆin a manner that promotes and enhances his or her sense of well- being, levelˆof satisfaction with life, and feeling of self-worth and self-esteem.staff are expected to knock and request permission before enteringˆresidents` rooms.

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	03/26/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 a comprehensive care planˆ(a document that outlines a resident's healthcare needs, goals, and the interventions planned to achieve those goals) by failing to: a. Develop a care plan for a skin tear (a wound caused by shear, friction, and/or blunt force resulting in separation of skin layers) sustained during a fall incident for one of five sampled residents (Resident 30) investigated under the Accidents care area. This deficient practice had the potential to result in failure to deliver the necessary care and services to Resident 30. b. Develop a care planˆregarding theˆrefusalˆof the 2025/2026 COVID-19ˆ(an infectious disease caused by the SARS-CoV-2 virus)ˆandˆinfluenza (also known asˆthe flu, a contagious respiratory illness caused by influenza viruses that infectsˆthe nose, throat, and lungs)ˆvaccinationsˆ(medications used to prevent diseases usually given by injection or by mouth)ˆfor one of five sampled residents (Resident 44) investigatedˆforˆimmunizationsˆ(the action of making a person or animal resistant to a particular infectious disease or pathogen, typically by vaccination).ˆ ˆ This deficient practiceˆhad the potential for Resident 44ˆto be at a higher risk of developing a respiratory infection,ˆobtainingˆfurther healthˆcomplications from the infection,ˆand spreadingˆtheˆinfection to other residents.ˆ Findings: a. During review of Resident 30's admission Record, the admission Record indicated that the facility admitted the resident on 1/27/2026 with diagnoses that included depression (a serious, common mood disorder causing persistent sadness, loss of interest, and physical symptoms that disrupt daily life) and hypertension (high blood pressure). During a review of Resident 30's Minimum Data Set (MDS - a resident assessment tool), dated 1/30/2026, the MDS indicated the resident's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was impaired and the resident required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene, shower, lower body dressing, putting on/taking off footwear and partial/moderate assistance (helper does less than half the effort) with oral hygiene, upper body dressing and personal hygiene. During a concurrent interview and record review on 03/25/2026 at 9:08 with Licensed Vocational Nurse 5 (LVN 5), reviewed Resident 30`s Change of Condition (COC-ˆany sudden or significant deviation from a patient's baseline physical, cognitive, functional, or behavioral status) dated 3/17/2026 and care plan (CP) for Actual Fall with skin tear. The COC indicated Resident 30 had a fall incident and sustained a skin tear to the right antecubital measuring 3-centimeter (cm-unit of measurement) length by 1 cm width. The CP's objective indicated the resident's injured areas would be resolved without complication. LVN 5 stated that the care plan was not resident-centered, as it did not include specific interventions to address the resident's skin tear and a target date to evaluate the effectiveness of the treatment. LVN 5 stated that without specific interventions identified in the CP, licensed nurses may not be able to provide the necessary care and services to promote the healing of the skin tear sustained after the fall and had the potential to delay treatment and place the resident at risk for infection. During a review of the facility`s policy and procedure (P&P) titled Care Plans, Comprehensive Person-Centered, last reviewed on 1/5/2026, the P&P indicated that The comprehensive, person-centered care plan includes measurable objectives and timeframes, describes the services that are to be furnished to attain or maintain the resident`s highest practicable physical, mental, and (continued on next page)

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	03/26/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	psychosocial well-being. b. Duringˆaˆreview ofˆResident 44'sˆadmission Record, theˆadmission Recordˆindicatedˆtheˆfacilityˆoriginallyˆadmitted theˆresidentˆonˆ10/17/2022 and most recently readmitted the resident on 4/5/2025ˆwith diagnoses including, but not limited to,ˆdiabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing)ˆand acute respiratory failure (a condition where the lungs cannot release enough oxygen into the blood)ˆwith hypoxiaˆ(an insufficient amount of oxygen in your body tissues).ˆ ˆˆ During a review ofˆResident 44's MDS dated [DATE],ˆthe MDS indicated the residentˆhad severely impaired cognitive (relating to or involving the processes of thinking and reasoning)ˆskills for daily decision making and never or rarely made decisions. The MDS indicatedˆResident 44ˆwas dependent (helper doesˆall ofˆthe effort) for all activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily).ˆ ˆ During a concurrent interviewˆand record reviewˆon 3/26/2026 at 10:15ˆa.m.ˆwith theˆInfection Preventionist, Resident 44'sˆImmunization Reportˆand care planˆwere reviewed. Resident 44's Immunization Reportˆindicatedˆthe resident had not received the updated 2025/2026 COVID-19 or influenza vaccinations.ˆThe IP stated Resident 44ˆwas not capable of makingˆher own decisions, and her representative had refused the vaccines.ˆResident 44's care plan did notˆindicateˆthe resident had not received these vaccinations or any interventionsˆregardingˆthe representative'sˆrefusal.ˆThe IPˆstatedˆa care plan should be madeˆregardingˆtheseˆrefusals,ˆso nursing staff knows toˆmonitorˆthe resident for in case they develop anyˆsymptoms of the flu or COVID, to reeducate the resident's representative, and to preventˆillness.ˆ ˆ During aˆreview of the facility's policy and procedureˆ(P&P)ˆtitled, Care Plans, Comprehensive Person-Centered,ˆlast reviewedˆ1/5/2026, the P&PˆindicatedÂ a comprehensive person-centered care plan that includes measurable objectives and timetablesˆto meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident.ˆThe P&P furtherˆindicatedˆassessments ofˆtheˆresident are ongoing and care plans are revised as information about the resident and resident's condition changes.ˆ

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	03/26/2026

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to properly use the air redistribution mattress (a specialized mattress that continuously circulates air) when it was turned off for one of four sampled residents (Resident 54). This failure had the potential to result in development of pressure ulcers (localized pressure-related damage to the skin and/or underlying tissue usually over a bony prominence), increased skin breakdown and slower healing. Findings: During a review of Resident 54's admission Record, the admission Record indicated Resident 54 was admitted on [DATE] with diagnoses that included metabolic encephalopathy (a brain dysfunction that causes confusion, memory loss or loss of consciousness), cerebral infarction (a type of stroke, loss of blood flow to a part of the brain), and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 54's physician's order, dated 1/25/2025, the physician's order indicated a PRM set at level three should be used for skin integrity management. During a review of Resident 54's Braden Scale (an assessment tool used to predict a resident's risk of developing pressure related damage to the skin and/or underlying tissue usually over a bony prominence) dated 2/4/2026, the Braden Scale indicated Resident 54 is at high risk of having pressure related skin damage. During a review of Resident 54's Minimum Data Set (MDS-a comprehensive assessment and screening tool) dated 2/5/2026, the MDS indicated Resident 54 has severely impaired cognitive skills for daily decision making. Resident 54 requires a helper to do all the effort for activities of daily living (ADL-routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During an interview on 3/26/2026 at 10:15 am with Licensed Vocational Nurse (LVN) 2, LVN 2 stated, the facility started using a new pressure redistribution mattress (PRM). These mattresses are used for those with pressure ulcers as well as those that are bed bound (unable to leave one's bed). During a concurrent observation and interview on 3/26/2026 at 11:15 am with the Director of Nursing (DON), the PRM was turned off. The DON stated the power was off on the PRM. When the power is off on the PRM, it cannot control the air flow at level 3 as ordered. The DON further stated the PRM being turned off places Resident 54 at risk of developing pressure related skin damage and skin that will not be maintained. During a review of the facility's PRM user-service manual dated 2022, the service manual indicated loss of power requires pump hoses to be disconnected from the mattress to continue air redistribution in the mattress. During a review of the facility's policy and procedure (P&P) titled Support Surface Guidelines, revised 2013, the P&P indicated any individual at risk for developing pressure ulcers should be placed on a redistribution support surface.

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	03/26/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 accurately document orthostatic blood pressure (taking blood pressure measurements when lying, sitting, and standing to detect for significant drop in blood pressure during each position change) measurements for one of five sampled residents (Resident 4). This failure had the potential to result in residents receiving the wrong treatments, physician miscommunication and inconsistent care. Findings: During a review of Resident 4's admission Record, the admission record indicated Resident 4 was admitted on [DATE] with diagnoses that included sepsis (a life threatening blood infection), psychotic disorder (a serious mental illness causing a loss of touch with reality), and acute respiratory failure with hypoxia (a critical condition defined by severely low blood oxygen). During a review of Resident 4's Minimum Data Set (MDS-a comprehensive assessment and screening tool) dated 1/12/2026, the MDS indicated Resident 4 had severely impaired cognitive skills for daily decision making and required a helper to do more than half of the effort for toileting hygiene, showers and baths, dressing, sit to lying, and lying to sitting on the side of bed. During a review of Resident 4's Order Summary Report (OSR) dated March 2026, the OSR indicated to monitor Resident 4's orthostatic blood pressure while lying and sitting daily and report a drop in blood pressure to the physician. During a review of Resident 4's Medication Administration Record (MAR) dated March 2026, the MAR indicated the same blood pressure while Resident 4 was lying and sitting on eight different days. During a concurrent interview and record review on 3/25/2026 at 2:45 pm with Licensed Vocational Nurse (LVN) 1, Resident 4's MAR dated March 2026 was reviewed. The MAR indicated LVN 1 had the same blood pressure reading while Resident 4 was lying and sitting that morning. LVN 1 stated the lying and sitting blood pressure reading were different and the documented blood pressure was taken while Resident 4 was lying down. LVN 1 further stated the orthostatic blood pressure readings are always different between lying and sitting. During a concurrent interview and record review on 3/26/2026 at 11:00 am with the Director of Nursing (DON), Resident 4's Weights and Vitals Summary for March 2026 were reviewed. The Weights and Vitals Summary indicated, only a lying blood pressure was taken on the morning of 3/25/2026. The DON stated orthostatic blood pressure for Resident 4 cannot be determined due to inaccurate documentation. The DON further stated inaccurate documentation will not show if the orthostatic blood pressure was taken which can cause miscommunication with the interdisciplinary team. During a review of the facility's policy and procedure (P&P) titled, Charting and Documentation, revised July 2017, the P&P indicated, Documentation in the medical record will be objective, complete, and accurate.

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	03/26/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to implement appropriate infection control practices for one of four residents (Resident 26) reviewed during the Infection Control task by failing to ensure Certified Nursing Assistant 1 (CNA 1) performed hand hygiene (the process of cleaning hands with soap and water or alcohol-based sanitizer to remove germs and prevent the spread of infections) after handling a soiled meal tray and prior to delivering a meal to Resident 26. The deficient practice had the potential to spread infection and cross contamination (the physical movement or transfer of harmful bacteria [germs] from one person, object, or place to another) among staff and other residents. Findings:ˆ During a review of Resident 26's admission Record (AR), the AR indicated the facility admitted the resident on 3/31/2020ˆwith diagnosis including,ˆmajor depressive disorder (a serious mental health condition characterized by persistent, severe sadness, loss of interest, and low energy lasting at least two weeks) and hypertension (high blood pressure). During a review of Resident 26's Minimum Data Set (MDS-a standardized assessment and care screening tool) datedˆ3/02/2026, the MDS indicated the resident had the ability to make self-understood and the ability to understand others. The MDS indicated that Resident 26 requiredˆsupervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with toileting hygiene, shower, lower body dressing and setup or clean-up assistance (helper sets up or cleans up; resident completes activity) with eating, oral hygiene, upper body dressing, putting on/taking off footwear and personal hygiene. During a concurrent observation and interview on 3/28/2026 at 12:15 p.m. with Certified Nurse Assistant 1 (CNA 1) outside of the main dining room, observed CNA 1 receive a finished meal tray from another staff which contained a cup of ice cream and crumpled plastic shrink wrap. CNA 1 disposed these items into a trash bin. CNA 1 did not perform hand hygiene (washing hands or using hand sanitizer) after discarding the trash. CNA 1 then proceeded to an open meal cart with three new meal trays and a container of soup. Upon reaching Resident 26's room, CNA 1 removed the soup container from the meal cart using bare hands, entered the room, placed the food on the overbed table, and removed the lid. CNA 1 was not observed performing hand hygiene before delivering the meal to Resident 26. CNA 1 stated that she should have performed hand hygiene, either by washing her hands or using a hand sanitizer after discarding items from a soiled tray and prior to delivering the food to Resident 26, to prevent infection and cross contamination among residents and staff. During a review of the facility`s policy and procedure (PP) titled Handwashing/Hand Hygiene, last reviewed on 1/05/2026, the PP indicated that This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infection.all personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors.hand hygiene is indicated immediately after touching the resident`s environment. ˆ ˆ

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	03/26/2026

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 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. Based on observation, interview, and record review, the facility failed to ensure the double door exit in the middle station (MSDDE) was fully sealed when closed and did not have gaps, which created an opening from top to bottom measuring 72 inches in length and 1/3 of an inch in width for one of three doors in the facility. This deficient practice created an entry point and access for insects to get inside the building which could potentially transmit insect borne illnesses to the 94 out of 94 residents in the facility. Findings: During a concurrent observation and interview on 3/25/2026 at 12:54 p.m., with the Maintenance Director (M-Dir.) while inspecting the MSDDE, the M-Dir stated that the exit doors must always be closed and sealed to prevent insect infestation in the facility. The M-Dir confirmed that the MSDDE had a wide opening, allowing visibility of cars passing through from the gaps in the double door. The M-Dir measured the opening which measured 72 inches in length and 1/3 of an inch in width. The Medical Director (M-Dir) stated that he would immediately go to Home Depot to obtain materials to seal the door. The M-Dir further stated that the gap could serve as an entry point for insects, such as flies and mosquitoes, which could potentially increase the risk of infection for residents in the facility During a review of the facility`s policy and procedure (P&P) titled Homelike Environment, last reviewed on 1/05/2026, the P&P indicated that The facility staff and management maximize, to the extent possible, the characteristics of the facility that reflect a personalized, home like setting. These characteristics include clean, sanitary and orderly environment. During a review of the facility`s policy and procedure (P&P) titled Pest Control, last reviewed on 1/5/2026, the P&P indicated that Maintenance services assist, when appropriate and necessary, in providing pest control services.