STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056149	A. Building B. Wing	07/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
California Healthcare and Rehabilitation Center	6700 Sepulveda Blvd. Van Nuys, CA 91411

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 42275 Based on observation, interview, and record review, the facility failed to provide reasonable accommodation of resident needs by failing to ensure the call light (an alerting device for nurses or other nursing personnel to assist a resident when in need) was within reach for one of five sampled residents (Resident 1). This deficient practice had the potential to result in a delay with resident care, possible injury to residents when unable to obtain the needed care and services and residents not receiving assistance with activities of daily living (ADL- tasks of everyday life such as eating, dressing, getting into or out of a bed or chair, taking a bath or shower, and using the toilet). Findings: During a review of Resident 1's Admission Record indicated the facility admitted the resident on 4/22/2024 with diagnoses that included cerebrovascular disease (conditions that affect blood flow to the brain), skull (the bony framework of the head) fracture (broken bone), and seizure (a sudden, uncontrolled burst of electrical activity in the brain causing changes in behavior, movements, feelings and levels of consciousness [the state of being aware of and responsive to one's surroundings]). During a review of Resident 1's Minimum Data Set (MDS- a standardized assessment and screening tool) dated 5/2/2024, indicated Resident 1's cognition (mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was moderately impaired and that Resident 1's vision (ability to see in adequate light) was highly impaired (object identification is in question, but eyes appear to follow objects). The MDS further indicated that Resident 1 was dependent on staff with oral hygiene, toileting hygiene, shower/bathing, upper/lower body dressing, personal hygiene, bed mobility (movement), and transfer. During a review of Resident 1's untitled care plan initiated on 5/2/2024 and revised on 5/21/2024, indicated, Resident 1 had self-care deficits (an inability to perform certain daily functions related to health and well-being) related to Resident 1's medical conditions, cognitive deficits, visual deficits, and muscular weakness. The care plan indicated a goal for Resident 1 to be clean, dry, and well-groomed daily. The interventions included to assist Resident 1 with ADLs, to ensure Resident 1's call light is within reach and to attend to Resident 1's needs promptly. (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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and concurrent interview with the Director of Staff Development (DSD) and the Infection Preventionist Nurse (IPN), in Resident 1's room, on 7/29/2024 at 9:20 a.m., observed Resident 1's call light placed on the seat of Resident 1's wheelchair, under Resident 1's clothing tangled with Resident 1's belongings and was out of Resident 1's reach. The IPN confirmed the finding and stated that the Resident 1's call light was not within Resident 1's reach. The IPN stated residents' call light should be always within reach. During a review of the facility's policy and procedure titled Answering the Call Light, last revised on 09/2022, last reviewed 7/16/2024, indicated it is the facility's policy to ensure timely responses to the resident's request and needs. The policy and procedure indicated to ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 42275 Based on observation, interview, and record review the facility failed to provide care and services to maintain good grooming and personal hygiene for one of five sampled residents (Resident 1). This deficient practice resulted in Resident 1 having dirty fingernails that had the potential to result in a negative impact on the resident's self-esteem and self-worth. Findings: During a review of Resident 1's Admission Record indicated the facility admitted the resident on 4/22/2024 with diagnoses that included cerebrovascular disease (conditions that affect blood flow to the brain), skull (the bony framework of the head) fracture (broken bone), and seizure (a sudden, uncontrolled burst of electrical activity in the brain causing changes in behavior, movements, feelings and levels of consciousness [the state of being aware of and responsive to one's surroundings]). During a review of Resident 1's Minimum Data Set (MDS- a standardized assessment and screening tool) dated 5/2/2024, indicated Resident 1's cognition (mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was moderately impaired and that Resident 1's vision (ability to see in adequate light) was highly impaired (object identification is in question, but eyes appear to follow objects). The MDS further indicated that Resident 1 was dependent on staff with oral hygiene, toileting hygiene, shower/bathing, upper/lower body dressing, personal hygiene, bed mobility (movement), and transfer. During a review of Resident 1's untitled care plan initiated on 5/2/2024 and revised on 5/21/2024, indicated, Resident 1 had self-care deficits (an inability to perform certain daily functions related to health and well-being) related to Resident 1's medical conditions, cognitive deficits, visual deficits, and muscular weakness. The care plan indicated a goal for Resident 1 to be clean, dry and well-groomed daily. The interventions included to assist Resident 1 with Activities of Daily Living (ADL - tasks of everyday life) and to assist Resident 1 with grooming and trimming of fingernails. During an observation and concurrent interview with the Director of Staff Development (DSD) and the Infection Preventionist Nurse (IPN) on 7/29/2024 at 9:16 a.m., observed Resident 1's fingernails in Resident 1's room. The DSD stated that Resident 1's fingernails had black substance and needed to be cleaned and trimmed right away. The DSD further stated that resident's fingernails should always be kept clean. During an interview with the Director of Nursing (DON) on 7/29/2024 at 2:10 p.m., the DON stated that is the responsibility of all nursing staff to ensure resident's fingernails were clean and trimmed at all times. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure titled Activities of Daily Living (ADL), Supporting, last revised 03/2018, last reviewed 7/16/2024, indicated, Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene Appropriate care and services will be provided for residents who are unable to carry out ADLS independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. hygiene (bathing, dressing, grooming, and oral care).

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. 42275 Based on interview and record review, the facility failed to ensure that the Physician Progress Notes (record that documents the physician's role in the assessment, evaluation, and care of residents) were completed as required for one of five sampled residents (Resident 1). This deficient practice had the potential for inconsistent care coordination due to incomplete records and placed Resident 1 at risk for poor continuity of care and care needs. Findings: During a review of Resident 1's Admission Record indicated the facility admitted the resident on 4/22/2024 with diagnoses that included cerebrovascular disease (conditions that affect blood flow to the brain), skull (the bony framework of the head) fracture (broken bone), and seizure (a sudden, uncontrolled burst of electrical activity in the brain causing changes in behavior, movements, feelings and levels of consciousness [the state of being aware of and responsive to one's surroundings]). During a review of Resident 1's Minimum Data Set (MDS- a standardized assessment and screening tool) dated 5/2/2024, indicated Resident 1's cognition (mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was moderately impaired and that Resident 1's vision (ability to see in adequate light) was highly impaired (object identification is in question, but eyes appear to follow objects). The MDS further indicated that Resident 1 was dependent on staff with oral hygiene, toileting hygiene, shower/bathing, upper/lower body dressing, personal hygiene, bed mobility (movement), and transfer. During a review of Resident 1's Physician Order dated 5/1/2024, timed at 3:23 p.m., indicated an order for an Ear Nose and Throat (ENT - medical conditions or diseases affecting the ear, nose, and throat) appointment on 5/7/2024 at 2:30 p.m. During a review of Resident 1's Physician Progress Notes, there were no Physician Progress Notes found related to Resident 1's ENT appointment visit on 5/7/2024. During a review of Resident 1's Physician's Order dated 7/8/2024, timed at 1:18 p.m. indicated an order for a hearing aid (a small electronic device worn in or behind the ear) appointment for Resident 1 on 7/18/2024 at 1:30 p.m. During a review of Resident 1's Nursing Progress Notes dated 7/18/2024, timed at 3:13 p.m., indicated Resident 1 returned from the hearing aid appointment. During a review of Resident 1's Physician Progress Notes, there were no Physician Progress Notes found related to Resident 1's hearing aid appointment visit on 7/18/2024. During a review of Resident 1's Physician Order dated 7/8/2024, timed at 10:56 a.m., indicated an order for a follow-up ENT appointment on 7/23/2024 at 10:20 a.m. to go over Resident 1's audiology (a branch of science dealing with hearing, balance, and related disorders) exam results. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Nursing Progress Notes dated 7/23/2024, timed at 12:45 p.m., indicated, Resident 1 returned from the ENT appointment. During a review of Resident 1's Physician Progress Notes, there were no Physician Progress Notes found related to Resident 1's hearing aid appointment visit on 7/23/2024. During a concurrent interview and record review with Licensed Vocational Nurse 1 (LVN 1) on 7/29/2024 at 1:00 p.m., LVN 1 reviewed Resident 1's Physician's Orders related to the ENT and audiology appointments from 4/22/2024 to 7/29/2024. LVN 1 stated that there were no Physician Progress Notes found for the following appointment visits: 5/7/2024, 7/18/2024 and 7/23/2024. LVN 1 further stated that the facility received ENT consultation notes from the ENT clinic on the same day (7/29/2024), for the services provided on 5/7/2024, and 7/23/2024. LVN 1 stated that the clinic should sent the Physician's Progress Notes to the facility on the same day of the visit where medical care or services were provided to the resident. During an interview with the Director of Nursing (DON) on 7/29/2024 at 2:15 p.m., the DON reviewed the ENT Physician Progress Notes received for Resident 1 on 7/29/2024, for the ENT services provided on 5/7/2024, and 7/23/2024. The DON stated that the facility should have ensured receipt of the Physician's Progress Notes the same day of the appointment visit when the resident received the services or treatments. During a review of the facility's policy and procedure titled Physician Services, last revised on 2/2021, last reviewed on 7/16/2024, indicated, Physician orders and progress notes are maintained in accordance with current OBRA (stands for Omnibus Budget Reconciliation Act, also known as the Nursing Home Reform Act of 1987, setting federal standards of how care should be provided to residents) regulations and facility policy.