

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056149	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/20/2024
NAME OF PROVIDER OR SUPPLIER California Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42275</p> <p>Based on observation, interview, and record review, the facility failed to ensure that the resident's fingernails of two of five sampled residents (Resident 2 and 3) were not dirty as evidence by black substances under the tip of the nails.</p> <p>This deficient practice resulted in Resident 2 and 3 having dirty fingernails that had the potential to result in a negative impact on the resident's self-esteem and self-worth.</p> <p>Findings:</p> <p>1. During a review of Resident 2 ' s Admission Record, the Admission Record indicated that the facility admitted Resident 2 on 5/20/2024 and readmitted Resident 2 on 7/29/2024 with diagnoses that included dementia (a decline in mental function that affects a person's ability to think, remember, and reason), tracheostomy(a surgical procedure to create an opening through the neck into the trachea [windpipe]), and gastrostomy tube (g-tube: a tube inserted through the belly that brings nutrition directly to the stomach).</p> <p>During a review of Resident 2 ' s Minimum Data Set (MDS- a standardized assessment and screening tool) dated 8/5/2024, the MDS indicated Resident 2 ' s cognition (mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was severely impaired. The MDS further indicated that Resident 2 was dependent on staff with oral hygiene (keeping a resident clean), toileting hygiene, shower/bathing, upper/lower body dressing, and bed mobility (movement).</p> <p>During a review of Resident 2 ' s untitled care plan initiated on 6/4/2024 and revised on 7/18/2024, the care plan indicated that Resident 2 had self-care deficits (when someone is unable to perform daily tasks that are related to their health and well-being) related to Resident 2 ' s medical conditions that included cognitive deficits impairments in mental processes that affect a person's ability to acquire knowledge, understand the world, and act in it and joint (the place where two or more bones meet and connect) limitation (when a joint can't move as freely as it normally would). The care plan indicated a goal for Resident 2 to be clean, dry, and well-groomed daily, and one of interventions was indicated to assist Resident 2 with grooming and trimming of fingernails.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview with the Subacute (providing intensive services for medically fragile and technically dependent residents) Director (SD) on 8/19/2024 at 2:56 p.m., the SD observed Resident 2 ' s fingernails inside Resident 2 ' s room. The SD stated that Resident 2 ' s fingernails had yellowish to blackish substances under the tip of the nail. SD further stated that Resident 2 ' s middle fingernail on the left hand was long and curved. SD stated that the facility will cut, trim, and clean Resident 2 ' s fingernails.</p> <p>2. During a review of Resident 3 ' s Admission Record, the Admission Record indicated the facility admitted Resident 3 originally on 11/9/2022 and readmitted Resident 3 on 7/16/2024 with diagnoses that included cerebral (relating to the brain) infarction (death of tissue resulting from a failure of blood supply), right hand contracture (a permanent tightening of the muscles, skin, and nearby tissues that caused the joints to shorten and become very stiff), left hand contracture, tracheostomy, and gastrostomy tube.</p> <p>During a review of Resident 3 ' s MDS dated [DATE], the MDS indicated Resident 3 ' s cognition was severely impaired. The MDS further indicated that Resident 3 was dependent on staff with oral hygiene, toileting hygiene, shower/bathing, upper/lower body dressing, personal hygiene, and rolling left and right on the bed.</p> <p>During a review of Resident 3 ' s untitled care plan initiated on 12/15/2022 and revised on 2/29/2024, the care plan indicated, Resident 3 had self-care deficits related to Resident 3 ' s medical conditions that included joint limitation and muscular weakness. The care plan indicated a goal for Resident 3 to be clean, dry, and well-groomed daily. One of interventions was indicated to assist Resident 3 with grooming and trimming of fingernails.</p> <p>During a concurrent observation and interview with the SD on 8/19/2024 at 3 p.m., the SD observed Resident 3 ' s fingernails inside Resident 3 ' s room. The SD stated that Resident 3 ' s fingernails on both hands were long and dirty with a black color substance under the tip of fingernails. SD stated that Resident 3 ' s fingernails needed to be cleaned and trimmed.</p> <p>During a review of the facility ' s policy and procedure titled Activities of Daily Living (ADL), Supporting, revised 03/2018 and last reviewed 7/16/2024, the policy indicated that Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good . 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).</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42275</p> <p>Based on observation, interview and record review, the facility failed to ensure one of five sampled residents (Resident 3) was provided with a left-hand splint (a device that supports and protects the hand and wrist, and keeps them positioned correctly) to reduce further contractures (a permanent tightening of the muscles, skin, and nearby tissues that causes the joints to shorten and become very stiff) of Resident 3 ' s left hand.</p> <p>This deficient practice placed Resident 3 at increased risk for worsening and further development of contractures.</p> <p>Findings:</p> <p>During a review of Resident 3 ' s Admission Record indicated the facility admitted the resident originally on 11/9/2022 and readmitted on [DATE] with diagnoses that included cerebral infarction (a type of stroke that occurs when blood flow to the brain is blocked, causing brain tissue to die), right hand contracture, left hand contracture, tracheostomy (a surgical procedure to create an opening through the neck into the trachea [windpipe]), and gastrostomy (a surgical procedure that creates an opening in the abdomen and into the stomach, allowing for a tube to be inserted for food and medication administration).</p> <p>During a review of Resident 3 ' s Minimum Data Set (MDS- a standardized assessment and screening tool) dated 6/5/2024, indicated Resident 3 ' s cognition (mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was severely impaired. The MDS further indicated that Resident 3 was dependent on staff with oral hygiene, toileting hygiene, shower/bathing, upper/lower body dressing and personal hygiene.</p> <p>During a review of Resident 3 ' s Physician ' s Order Summary Report dated 7/17/2024, indicated that Restorative Nursing Assistant (a healthcare professional who helps residents maintain or regain their physical function and quality of life) to apply bilateral (having or involving two sides) elbow splints, right hand splint, and left knee splint for four to six hours or as tolerated daily for seven days with daily skin checks.</p> <p>During a review of Resident 3 ' s untitled care plan initiated on 12/15/2022 and revised on 2/29/2024, indicated Resident 3 had alteration in joint mobility as evidenced by limitations noted in the right hand and left hand. The care plan indicated a goal to minimize the risk for further loss of range of motion daily. The interventions included were for RNA to apply both (left and right) hand splints for four to six hours or as tolerated daily for seven days with daily skin checks and to position Resident 3 to prevent further contractures with pillow or splints as needed.</p> <p>During a concurrent observation and interview with the Subacute Director (SD) on 8/19/2024 at 3:00 p.m., the SD observed Resident 3 ' s both hands and stated that Resident 3 ' s both hands were contracted.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review on 8/20/2024 at 9:45 a.m., with the Director of Rehabilitation (DOR), the DOR reviewed Resident 3 ' s physician ' s order dated 7/17/2024 to apply bilateral elbow splints, right hand splint, and left knee splint for four to six hours or as tolerated daily for seven days with daily skin checks for Resident 3. The DOR stated that Resident 3 should have been provided with a left-hand splint for his left-hand contracture. The DOR further stated that the SD should have completed a reassessment the next day (on 8/20/2024) and should have clarified the physician ' s orders for the use of left-hand splint. The DOR further stated that the purpose of applying splints four to six hours daily as tolerated was to prevent further contractures.</p> <p>During a review of the facility ' s policy and procedure titled, Joint Mobility Contracture Management Program last reviewed on 7/16/2024, indicated, To reduce contractures in upper or lower extremities, and to promote function and skin integrity The therapist shall make recommendations regarding special positioning, range of motion or stretching program, handrolls or splints and any special adaptive positioning equipment Nursing shall assure that if the resident is readmitted after an acute hospital stay, the physician and therapist shall be consulted regarding continuing the splints/positioning devices.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>42275</p> <p>Based on observation, interview, and record review, the facility failed to implement infection control practices by failing to ensure two of 11 sampled staff (Certified Occupational Therapy Assistant 1 [COTA 1] and Physical Therapy Assistant 1 (PTA 1) wore isolation gowns (protective apparel, used to protect the wearer from the spread of infection or illness if the wearer comes in contact with potentially infectious liquid and solid material) while providing therapy services to Resident 4, in Resident 4 ' s room which was placed on enhanced standard precautions (ESP - a set of infection control measures that involve wearing gowns and gloves during high-contact resident care activities for residents at increased risk of Multidrug- Resistant Organisms [MDROs - bacteria that have become resistant to certain antibiotics [a medicine that fights bacterial infections] such as residents with wounds or indwelling medical devices [a medical device that is left inside the body for variety of reasons including to administer food or medications]).</p> <p>These deficient practices had the potential to result in the spread of infection placing residents, staff, and visitors at risk for infection.</p> <p>Findings:</p> <p>During a review of Resident 4 ' s Admission Record, indicated the facility admitted Resident 4 on 3/21/2024 with diagnoses with that included cerebral infarction (a type of stroke that occurs when blood flow to the brain is blocked, causing brain tissue to die), seizures (a burst of uncontrolled electrical activity between brain cells that causes temporary abnormalities in muscle tone or movements, behaviors, sensations or states of awareness), tracheostomy (a surgical procedure to create an opening through the neck into the trachea [windpipe]), and gastrostomy (a surgical procedure that creates an opening in the abdomen and into the stomach, allowing for a tube to be inserted for food and medication administration).</p> <p>During a review of Resident 4 ' s Minimum Data Set (MDS - a standardized resident assessment and care screening tool) dated 7/3/2024, indicated Resident 4 was dependent on staff with oral hygiene, toileting hygiene, shower/bathing, upper/lower body dressing, personal hygiene, bed mobility (movement), and transfer.</p> <p>During a record review of Resident 4 ' s History and Physical dated 4/24/2024, indicated that Resident 4 did not have the capacity to understand and make decisions.</p> <p>During a record review of Resident 4 ' s Physician ' s Order Summary Report dated 5/1/2024, indicated that, the physician ordered for ESP to indwell medical devices and any open wounds.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview on 8/19/2024, at 1:45 p.m., observed COTA 1 and PTA 1 providing rehabilitation services (health care services that help residents regain or improve their physical abilities that have been lost or impaired) to Resident 4, in Resident 4 ' s bed. COTA 1 and PTA 1 were observed not wearing isolation gowns. COTA 1 stated that it was her first day at the facility and did not see the ESP signage before entering the room. PTA 1 confirmed the finding and stated that she was aware of the ESP signage and should have worn an isolation gown before entering Resident 4 ' s room and while providing rehabilitation services to Resident 4. PTA 1 stated that Resident 4 had tracheostomy, on tube feeding (a way to provide nutrition when a person cannot eat or drink safely by mouth) and had a wound.</p> <p>During an interview on 8/19/2024 at 1:53 p.m. with the Infection Prevention Nurse (IPN), the IPN stated that on the residents ' name plaque (a flat piece of metal, stone, wood, or plastic with writing on it that is attached to a wall or door), attached to a wall by the resident ' s door prior to entering the resident ' s room, a letter E mark was made to communicate to the facility staff that the resident was under ESP. The IPN further stated that the ESP signage was posted on the wall of each resident ' s head of the bed for awareness.</p> <p>During a review of the facility policy and procedure (P&P) titled Infection Control last reviewed on 7/16/2024, indicated This facility has established and will maintain an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>During a review of the facility provided ESP signage indicated to Wear gloves and a gown for the high-contact resident care activities below. Six (6) moments for ESP 1. Activities of daily living (dressing, grooming, bathing, changing bed linens, feeding). 2. Caring for devices & giving medical treatments .</p>		