

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 03/12/2025
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 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42275</p> <p>Based on interview and record review, the facility failed to ensure residents at risk for developing pressure ulcers localized damage to the skin and/or underlying tissue usually over a bony prominence) had their skin assessed and documented on a weekly basis per the facility policy and procedure (P&P) for two of three sampled residents (Resident 1 and Resident 2).</p> <p>This deficient practice had the potential to delay necessary treatments and services and to increase the residents' risk of skin breakdown.</p> <p>Findings:</p> <p>1. During a review of Resident 1's Admission Record, the Admission Record indicated the facility originally admitted Resident 1 to the facility on [DATE] and readmitted the resident on 12/05/2018 with diagnoses including diabetes mellitus (DM- a chronic condition that affects the way the body processes blood glucose [sugar]) and Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities).</p> <p>During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 12/21/2024, 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 severely impaired, and the resident was dependent on staff with oral/personal/toileting hygiene, upper/lower body dressing, bed mobility (movement) and transfer. The MDS further indicated that Resident 1 had a risk of developing pressure ulcers/injuries (PU/I).</p> <p>During a review of Resident 1's Order Summary Report, the Order Summary Report indicated the following physician orders:</p> <ul style="list-style-type: none"> - Treatment, renewal, site; sacrococcyx (the area at the base of the spine near the tailbone) skin integrity maintenance, cleanse with normal saline (NS - a saltwater solution), pat dry, apply skin barrier ointment, leave open to air every day shift for 30 days; Order Date: 2/19/2025, Start Date: 2/19/2025, and Stop Date: 3/21/2025. - Treatment, site; open blister on sacrococcyx; cleanse with NS, pat dry, apply thera-honey (used as a wound dressing), followed by collagen granules (used to promote wound healing process), cover dry dressing every day shift for 30 days; Order Date: 3/2/2025, Start Date: 3/2/2025, and Stop Date: 4/1/2025. <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 056149	If continuation sheet Page 1 of 3

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1's Care Plan Report, initiated on 12/16/2018 and last revised on 1/13/2025, the care plan indicated that Resident 1 was at risk for developing pressure sore and other types of skin breakdown related to fragile skin due to aging process, reduced mobility, and dementia. The care plan indicated an intervention for weekly body checks.</p> <p>During a review of Resident 1's weekly Licensed Nurses Note dated 2/23/2025, the weekly Licensed Nurses Note indicated Skin Management Protocols was not marked for skin clear/intact or skin alteration present.</p> <p>During a review of Resident 1's Change of Condition (COC- a sudden clinically important deviation from a resident's baseline in physical, cognitive, behavioral, or functional domains) Licensed Nurses Note, dated 3/5/2025, the COC Licensed Nurses Note indicated Skin Management Protocols was not marked for skin clear/intact or skin alteration present.</p> <p>During a concurrent interview and record review on 3/12/2025 at 4:45 p.m., with the Director of Nursing (DON), reviewed Resident 1's weekly Licensed Nurses Notes dated 2/23/2025 and Resident 1's COC Licensed Nurses Note dated 3/5/2025. The DON stated that the licensed nurses did not document for the section of skin management protocol and was left blank, so the facility was unable to provide information of Resident 1's skin condition and/or skin progress. The DON stated the skin condition and/or skin progress should be assessed and documented at least weekly by the licensed nurses.</p> <p>2. During a review of Resident 2's Admission Record, the Admission Record indicated the facility originally admitted Resident 2 to the facility on [DATE] and readmitted the resident on 2/18/2023 with diagnoses including right hip broken bone and dementia (a progressive state of decline in mental abilities).</p> <p>During a review of Resident 2's MDS dated [DATE], the MDS indicated the resident's cognitive skills for daily decision making was severely impaired, and the resident was dependent on staff with toileting hygiene and transfer and needed moderate assistance with upper/lower body dressing and bed mobility. The MDS further indicated that Resident 2 had a risk of developing PU/I.</p> <p>During a review of Resident 2's Care Plan Report, initiated on 11/19/2023 and last revised on 2/22/2025, the care plan indicated that Resident 2 was at risk for developing pressure sore and other types of skin breakdown related to aging process, incontinence of bowel and bladder, reduced mobility, and dementia. The care plan indicated an intervention for weekly body checks.</p> <p>During a review of Resident 2's weekly Licensed Nurses Note dated 2/23/2025 and 3/2/2025, the weekly Licensed Nurses Notes indicated Skin Management Protocols were not marked for skin clear/intact or skin alteration present.</p> <p>During a concurrent interview and record review on 3/12/2025 at 4:35 p.m., with the DON, reviewed Resident 2's weekly Licensed Nurses Notes dated 2/23/2025 and 3/2/2025. The DON stated that the licensed nurses should mark for skin clear/intact if no issues with the resident's skin, but the licensed nurses did not mark for Resident 2's skin conditions. The DON stated if not marked, the facility was unable to prove that Resident 2's skin was assessed weekly.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's P&P titled, Pressure Sore Management, last reviewed on 7/16/2024, the P&P indicated, All available measures shall be taken to reduce skin breakdown and pressure sores Individual care plan for management of skin condition will be developed as indicated.</p> <p>During a review of the facility's P&P titled, Licensed Nurses Notes, last reviewed on 7/16/2024, the P&P indicated, Weekly progress notes are to be written on each resident regardless of the amount of daily entries recorded. These progress notes shall include the following Any pertinent information to reflect an overall profile of the resident. When a licensed nurse is writing a weekly summary, the following records are to be reviewed to ensure that the information entered coordinates with the other discipline's documentation.</p>		