

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 11/18/2025
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)		
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 interview and record review the facility failed to accurately identify and assess the stage of a pressure ulcer (PU - a localized injury to skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) for one of ten sampled residents (Resident 3) and did not implement appropriate interventions when on 9/15/2025 Licensed Vocational Nurse 1 (LVN 1) documented Resident 3's pressure ulcer located in the sacrum (a large, triangular bone located at the base of the spine) area as a Deep Tissue Injury (DTI- a pressure injury with damage to underlying soft tissue which may present as a purple or maroon area of discolored intact skin or a blood-filled blister [fluid-filled sac on the skin]) instead of Unstageable (a PU with full thickness tissue loss where the base is completely covered by slough [a type of non-viable, dead tissue that is typically yellowish, soft, and stringy, or creamy in texture] or eschar [a hard, dry, leathery, black or brown layer of dead tissue that forms on the skin] making its true depth impossible to determine until the covering is removed). This deficient practice placed Resident 3 at potential risk for PU deterioration resulting in the resident not receiving appropriate care and services for wound management necessary to promote healing and prevent further wound complications. During a review of Resident 3's admission Record, the admission Record indicated that Resident 3 was originally admitted to the facility on [DATE] with diagnoses that included pneumonia (lung inflammation caused by infection), major depressive disorder (a treatable medical condition that involves persistent feelings of sadness, hopelessness, and a loss of interest or pleasure in daily activities) and acute kidney failure (the rapid loss of the kidney's ability to filter waste and balance fluids). During a review of Resident 3's Minimum Data Set (MDS- a resident assessment tool) dated 9/16/2025, the MDS indicated that Resident 3 had severely impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was dependent on staff with toileting hygiene, shower or bathing, dressing, personal hygiene, and mobility (movement). During a review of Resident 3's Skin and Wound Evaluation forms dated 9/6/2025 timed at 4:58 p.m.; 9/15/2025 timed at 10:41 a.m.; and 9/22/2025 timed at 11:36 a.m., the Skin and Wound Evaluation forms indicated the following: 1. On 9/6/2025, timed at 4:58 p.m., under the Stage section indicated that the wound was identified as a DTI located on the sacrum area, with measurements of 9.5 centimeters (cm - unit of measure) in length and 7.2 cm in width. The Skin and Wound Evaluation form further indicated light serosanguineous (containing or consisting of both blood and serous fluid [the clear, watery part of blood]) exudate (the fluid that leaks from blood vessels into the surrounding tissues), skin breakdown, and redness, with minimal pinkish drainage. 2. On 9/15/2025, timed at 10:41 a.m., under the Stage section indicated that the wound was identified as a DTI located on the sacrum area, with measurements of 5.0 cm in length and 5.0 cm in width with light serous exudate observed. 3. On 9/22/2025, timed at 11:36 a.m., under the Stage section indicated that the wound was identified as a DTI located on the sacrum area, with measurements of 7.2 cm in length and 6.2 cm in width with 60 percent (%) of granulation (the process of forming healthy, red, bumpy tissue as the wound heals) and 40% slough (a type of non-viable, dead tissue that is typically yellowish, soft, and stringy, or creamy in texture) with light serous exudate observed. During a review of Resident 3's (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Wound Care Notes documented by the Wound Care Specialist dated 9/17/2025, the Wound Care Notes indicated that on 9/17/2025, Resident 3 was seen, evaluated and treated Resident 3's wound. The Wound Care Notes indicated that Resident 3 had an unstageable pressure-induced tissue injury to the sacral (located near the sacrum) coccyx (tailbone) area measuring 7 cm in length, 6.2 cm in width and unable to determine (UTD) depth. A sharp excisional debridement (removes unhealthy tissue by cutting it off) of necrotic subcutaneous tissue (contains dead tissue, which is caused by a lack of blood flow, severe injury, or infection, and can appear black, brown, or yellow) was performed. During a concurrent interview and record review on 10/31/2025 at 3:30 p.m., with LVN 1, the Skin and Wound Evaluation forms dated 9/6/2025 timed at 4:58 p.m.; 9/15/2025 timed at 10:41 a.m.; and 9/22/2025 timed at 11:36 a.m. were reviewed. LVN 1 stated that on 9/15/2025, he (LVN 1) performed and completed the skin and wound evaluation for Resident 3 and documented his (LVN 1) findings on the Skin and Wound Evaluation form. LVN 1 stated that based on the wound's appearance and characteristics including the presence of exudate, Resident 3's wound on the sacrum area should have been identified as an unstageable PU rather than a DTI. LVN 1 stated that he (LVN 1) was unable to assess Resident 3's wound accurately. LVN 1 stated that appropriate interventions for an unstageable PU were not implemented; instead, interventions for a DTI were provided. LVN 1 further stated that he (LVN 1) should have assessed the resident (Resident 3) for pain as well, developed a care plan, and provided appropriate wound care management and treatment for Resident 3's unstageable PU. LVN 1 stated he (LVN 1) failed to recognize and document Resident 3's wound accurately, documenting it as a DTI instead. During an interview on 11/4/2025 at 3:20 p.m., with the Director of Nursing (DON), the DON stated that LVN 1 should have accurately identified and assessed Resident 3's wound. The DON stated that as a result of the inaccurate assessment, Resident 3 did not receive appropriate interventions, management and care for an unstageable PU, placing Resident 3 at risk for PU deterioration. During a review of the facility's policy and procedure (P&P) titled Staging Pressure Sores last reviewed on 10/20/2025, the policy indicated that it is the facility's policy to provide appropriate staging of pressure sores (pressure ulcers). During a review of the facility's P&P titled Pressure Sore Management, last reviewed on 10/20/2025, the policy indicated that all available measures shall be taken to reduce skin breakdown and pressure sores. Individual care plans for management of skin condition will be developed as indicated.		