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	01/06/2026

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review the facility failed to provide referrals to local agencies and support services that can assist residents' representatives with discharge planning and failed to notify a resident's representative of a denial of admission by the facility preferred by the resident's representative for the resident's discharge, in accordance with the facility's policy titled, Discharge Summary and Plan, for one of four sampled residents (Resident 1). This deficient practice had the potential to delay Resident 1's return to the community and placed the resident at risk for not receiving the necessary care and services related to the resident's discharge goals and needs.Findings: During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 11/6/2025 with diagnoses including malignant neoplasm (an abnormal growth of cells that grows uncontrollably, invades nearby healthy tissues, and can spread to other parts of the body, making it serious and potentially life-threatening) of ribs sternum (breastbone), and clavicle (collarbone), muscle weakness, and difficulty walking. During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 11/20/2025, the MDS indicated Resident 1 had intact cognition (the mental process involved in knowing, learning, and understanding things). The MDS indicated Resident 1 required setup or clean-up assistance with eating and was dependent on staff with oral hygiene, toileting hygiene, and personal hygiene. During a review of Resident 1's IDT (Interdisciplinary Team- a group of professionals from different fields [like doctors, nurses, therapists, social workers] who collaborate closely, sharing knowledge and coordinating efforts to provide comprehensive care for residents with complex needs, working towards shared goals rather than just individual tasks) - Resident Discharge Planning dated 11/9/2025, timed at 1:33 p.m., the IDT Resident Discharge Planning indicated the IDT has determined that Resident 1 preferred to return to community and the plan was to find an assisted living facility (a housing option for seniors or people with disabilities who need help with daily tasks like bathing, dressing, or medications, but do not require 24/7 nursing care, offering a balance of independence with personal support in a community setting with meals, activities, and staff available) or a board and care (a small, residential facility that provides non-medical care and supervision to adults who need help with daily activities but do not require 24-hour skilled nursing care) for the resident). During an interview on 12/31/2025 at 3:00 p.m. with Family Member 1 (FM 1), FM 1 stated she (FM 1) spoke to a staff member with the social services department and informed the staff that she would like Resident 1 to be discharged to a facility closer to her because she lives more than three hours away from the facility. FM 1 continued to state that she provided the name of the facility that she would like Resident 1 to be transferred to, however, she has not received a response from the social services staff. During a concurrent interview and record review on 1/5/2025 at 11:10 a.m. with the Social Services Director (SSD), the SSD reviewed Resident 1's IDT- Resident Discharge Planning dated 11/9/2026, which indicated that the plan was to discharge Resident 1 to a facility near FM 1 because FM 1 lives three hours (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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	away from the resident. The SSD stated that she (SSD) spoke to FM 1 and FM 1 provided the SSD with the name of the facility (Facility 2) that was closer to FM 1. The SSD stated that she (SSD) faxed Resident 1's clinical information to Facility 2 on 12/17/2025 per FM 1's request and received a response form Facility 2 on 12/18/2025 indicating that Facility 2 was unable to admit Resident 1. The SSD stated that she did not inform FM 1 that Facility 2 denied Resident 1's admission, and that she should have done so.When asked if the SSD provided names of other facilities or if the SSD provided other community resources to assist FM 1 in discharging Resident 1 closer to FM 1, the SSD stated that she did not provide additional resources or support to assist in Resident 1's discharge. The SSD stated that the SSD should have reached out to FM 1 and provided additional resources to assist FM 1 with Resident 1's discharge planning or identifying placement closer to closer to FM 1, as this is the responsibility of the SSD. The SSD acknowledged that she should have provided additional support and assistance to FM 1 to ensure a better quality of life for the resident. During an interview on 1/6/2026 at 2:21 p.m. with the Administrator (ADM), the ADM stated that IDT meetings are conducted to discuss the necessary services needed to be coordinated to ensure the safe discharge of residents. The ADM stated that the SSD should have assisted Resident 1's family in finding an appropriate facility closer to FM 1 and she (SSD) should have informed FM 1 of the denial of admission from another facility, as it is the family's right to be informed of matters affecting the resident. During a review of the facility policy and procedure (P&P) titled Discharge Summary and Plan, date reviewed 11/25/2025, indicated when a resident's discharge is anticipated a discharge summary and post discharge plan is developed to assist the resident with discharge. The post discharge plan is developed by the care planning interdisciplinary team with the assistance of the resident and his or her family and includes a. where the individual plans to reside; b. arrangements that have been made for follow-up care and services; e. how the IDT will support the resident and representative in the transition to post discharge care. The discharge plan is reevaluated based on changes in the residence condition or needs prior to discharge. The resident/representative is involved in the post discharge planning process and in forms of the final discharge plan. Residents are asked about their interest in returning to the community if the resident indicates an interest in returning to the community, he or she will be referred to local agencies and support services that can assist in accommodating the residents post discharge preferences.

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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 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 maintain accurate clinical records in accordance with accepted professional standards and practices for one of four sampled residents (Resident 1) by failing to ensure the Activity Director (AD) or activity assistant document the activities provided to Resident 1 from 11/6/2025 to 1/5/2026. This deficient practice placed the resident at risk of not receiving appropriate care due to inaccurate medical documentation.Findings: During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 11/6/2025 with diagnoses including malignant neoplasm (an abnormal growth of cells that grows uncontrollably, invades nearby healthy tissues, and can spread to other parts of the body, making it serious and potentially life-threatening) of ribs sternum (breastbone), and clavicle (collarbone), muscle weakness, and difficulty walking. During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 11/20/2025, the MDS indicated Resident 1 had intact cognition (the mental process involved in knowing, learning, and understanding things). The MDS indicated Resident 1 required setup or clean-up assistance with eating and was dependent on staff with oral hygiene, toileting hygiene, and personal hygiene. During a review of Resident 1's Activity assessment dated [DATE], timed at 11:04 a.m., the Activity Assessment indicated Resident 1's current preferred activity preferences were as follows: exercise/sports, watch television (tv), music stimulation, book tapes, and talking/conversing, and spiritual visit. The plan of care/recommendations part of the Activity Assessment indicated the recreation staff provided Resident 1 with an activity calendar, informed him (Resident 1) where recreation materials are available and discussed which groups he may like to attend. During an interview on 12/31/2025 at 3:00 p.m. with Family Member 1 (FM 1), FM 1 stated Resident 1 remained in bed in his room all day with no activities. During an interview on 1/5/2026 at 12:06 p.m. with the Activities Director (AD), the AD stated that the facility has 4 nursing stations and there is an activity assistant assigned to each nursing station. The AD stated the activity staff greet all residents every morning and discusses the activity calendar with the residents to determine who would like to attend activities in the activity room. The AD stated that activity staff conduct room visits for residents who choose not to attend group activities. The AD stated that Resident 1 does not typically join group activities and that activity assistants conduct room visits for Resident 1. The AD further stated that all room visits with residents are documented in the facility's computer system. During a concurrent interview and record review on 1/6/2025 at 9:25 a.m. with the AD, the AD reviewed Resident 1's documentation survey report for independent activity and room visits and stated that there was no documented evidence that Resident 1 received room visits by an activity assistant from 11/6/2025 to 1/5/2026. The AD stated that she conducted the room visits in station three (3), which was the resident's assigned unit. The AD stated that she (AD) did not document the activities provided for Resident 1 and acknowledged that there was no excuse for not documenting. The AD stated that it is important to document room visits and activities provided to residents to ensure the medical record accurately reflects that activity visits were conducted. During a review of the facility policy and procedure (P&P) titled Activity Program: Purpose & Policies, date reviewed 11/25/2025, the P&P indicated an activity program has the following benefits: Contributes to the residents rehabilitation to prevent further deterioration; promotes the coordination of activities and nursing goals; encourages motivation for activities of daily living and the resumption of as normal functioning as is reasonably possible; provides alternatives to compensate for loss of mental and physical capabilities; gives psychosocial support and understanding in helping (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident accept his or her illness and or limitations; creates in the resident the will to make his or her life more meaningful by using his or her physical and mental capacities to their fullest extent; and remains the residence sense of youthfulness self-respect and self-satisfaction. During a review of the facility P&P titled Charting and Documentation, date reviewed 11/25/2025, the P&P indicated health services provided to the resident progress toward the care plan goals or any changes in the residence medical physical functional or psychosocial condition shall be documented in the residence medical record the medical records should facilitate communication between the interdisciplinary team regarding the residence condition and response to care.