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	05/14/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility's licensed nurses failed to conduct accurate fall risk assessments for two of four sampled residents (Resident 1 and Resident 2).These deficient practices had the potential to increase the residents' risk for falls and fall-related injuries. a. During a review of Resident 1's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated that the facility originally admitted Resident 1 on 1/27/2025 and readmitted on [DATE] with diagnoses that included left femur (thigh bone) fracture (broken bone), cerebral infarction (stroke, loss of blood flow to a part of the brain resulting in damage to brain tissue), contractures (stiffening/shortening at any joint, that reduces the joint's range of motion [full movement potential of a joint]) left hand, right hand, and left ankle, functional quadriplegia (paralysis [loss of ability to move] from the neck down, including legs, and arms, usually due to a spinal cord injury), and osteoporosis (a medical condition that weakens bones, making them fragile and highly susceptible to fractures). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 4/8/2026, the MDS indicated that Resident 1's cognition (ability to think, reason, and function) was severely impaired. The MDS further indicated Resident 1 was dependent on staff for toileting, personal hygiene, showering/bathing, upper and lower body dressing, and rolling left and right in bed. Resident 1 also required maximal assistance with oral hygiene and required setup or clean-up assistance with eating. The MDS indicated that staff were unable to assess Resident 1's functional status for sitting to lying, lying to sitting on the side of the bed, sitting to standing, toilet transfers, and walking.During a review of Resident 1's Change in Condition (COC - an acute, abnormal alteration in a resident's physical or mental baseline) Evaluation form dated 5/3/2026, the COC Evaluation form indicated the following: Timed at 2:56 p.m., at 10:31 a.m., Resident 1 was found sitting on the floor mat with the resident's back leaning against the bed. Timed at 7 p.m., the facility received a radiology (diagnostic imaging, a series of tests that take pictures or images of parts of the body) report identifying a left distal femur fracture. Resident 1's physician was notified and ordered transfer of Resident 1 to General Acute Care Hospital 1 (GACH 1).During a review of Resident 1's Fall Risk Evaluation dated 4/5/2026, the Fall Risk Evaluation indicated the following:1.In the History, Current Status, Predisposing Conditions Section, the form instructed staff to conduct assessments upon admission and quarterly, at a minimum, thereafter, observe the resident status in the 11 clinical condition parameters listed below by assigning the corresponding score which best describes the resident. If the total score is 10 or greater, the resident should be considered at high risk for potential falls. Prevention protocol should be initiated immediately and documented on the care plan. Systolic Blood Pressure (SBP - the top [higher] number in a blood pressure reading, measuring the maximum pressure in your arteries when the heart contracts and pumps blood) was marked with no noted drop in SBP between lying and standing positions.2.In the Gait (a person's particular manner, style, or pattern of walking or running) and Balance Section, the evaluation indicated Resident 1 was unable to perform the function.During a review of Resident 1's Fall Risk Evaluation dated 5/3/2026, the Fall Risk Evaluation indicated the following:1.In the History, Current Status, Predisposing Conditions (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Section, the history of falls within the past three (3) months was marked as no falls, despite the COC Evaluation dated 5/3/2026 indicating Resident 1 had a fall on the same date. Additionally, the evaluation indicated no noted drop in SBP between lying and standing positions. 2.In the Gait and Balance Section, the evaluation indicated Resident 1 was not able to perform function.During an interview on 5/14/2026 at 3:47 p.m., with the Assistant Director of Nursing (ADON), the ADON reviewed Resident 1's Fall Risk Evaluations dated 5/3/2026 and stated that the fall risk evaluation was completed following the fall incident, however, the actual fall that occurred on 5/3/2026 was not included on the evaluation. The ADON was unsure whether the fall should have been included and stated she (ADON) would confirm with the facility consultant. The ADON further stated that the section regarding SBP, which was marked as no noted drop between lying and standing was not an appropriate selection for Resident 1 because the resident was unable to stand and was dependent on staff for all Activities of Daily Living (ADLs - activities such as bathing, dressing and toileting a person performs daily) prior to the fall incident. The ADON stated the evaluation form only provided three response options related to lying and standing blood pressure measurements and the electronic system would not allow the evaluation to be completed if the section was left blank; however, the selected response did not accurately reflect Resident 1's condition. b. During a review of Resident 2's Face Sheet, the Face Sheet indicated that the facility originally admitted Resident 2 on 1/7/2025 and readmitted on [DATE] with diagnoses that included acute (sudden, intense flare-up) respiratory failure (the lungs cannot get enough oxygen into the blood or cannot remove a waste gas from the blood), contractures of the left hand and elbow, and anemia (a condition where the body does not have enough healthy red blood cells).During a review of Resident 2's MDS dated [DATE], the MDS indicated that Resident 2's cognition was severely impaired. The MDS further indicated that Resident 2 was dependent on staff for toileting, personal hygiene, showering/bathing, and lower body dressing. The MDS indicated Resident 2 required maximal assistance with oral hygiene, upper body dressing, sit-to-stand activities, and transfers. During a review of Resident 2's COC Evaluation form dated 3/20/2026 timed at 3:28 p.m., the COC Evaluation form indicated, at 11:40 a.m., Resident 2 had a fall and sustained a small abrasion (superficial injury where the outer layer of skin is scraped or rubbed away) to the top of the resident's head. Resident 2's physician ordered a stat (immediately) skull (a collection of bones that form a protective structure for the brain) X-ray (a type of medical imaging that uses radiation to take pictures of the inside of the body) following the incident. During a review of Resident 2's Fall Risk Evaluation dated 3/20/2026, the Fall Risk Evaluation indicated the following:1.In the History, Current Status, Predisposing Conditions Section, the form instructed staff to conduct assessments upon admission and quarterly, at a minimum, thereafter, observe the resident status in the 11 clinical condition parameters listed below by assigning the corresponding score which best describes the resident. If the total score is 10 or greater, the resident should be considered at high risk for potential falls. Prevention protocol should be initiated immediately and documented on the care plan. Despite the COC Evaluation form dated 3/20/2026 indicating Resident 2 had a fall on the same date, the history of falls within the past three months was marked as no falls. During a review of Resident 2's Fall Risk Evaluation dated 3/20/2026, the Fall Risk Evaluation indicated a fall score of nine (indicating the resident was not identified as being at high risk for falls).During an interview on 5/14/2026 at 4:05 p.m., with the ADON, the ADON reviewed Resident 2's Fall Risk Evaluations dated 3/20/2026 and stated that the fall risk evaluation was completed after the fall incident; however, the actual fall that occurred on 3/20/2026 was not included in the evaluation. When the ADON was asked regarding the purpose of completing a fall risk evaluation following a fall incident, the ADON stated the evaluation was intended to reduce the risk of subsequent falls and to identify factors contributing to the resident's current fall incident so the facility could implement new interventions and/or revise existing interventions based on the resident's identified fall risk factors.During a review of the facility's policy and procedures (P&P) titled, Initial Fall Risk Assessment last reviewed on 11/25/2025, the P&P indicated, All residents will (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	be assessed using the initial fall risk assessment tool during admission and readmission. Each resident will be given a score, if the score is 10 or above, the resident will be considered as high risk for fall and a plan of care will be established immediately for implementation of interventions to attempt prevention. The plan of care will be reviewed by the Interdisciplinary Team (IDT - a group of different health professional - such as doctors, nurses, therapists, and social worker who meet regularly to create a single, coordinated care plan for a resident) quarterly and as needed for update of the resident's current needs.During a review of the facility's P&P titled, Promoting Safety, Reducing Falls last reviewed on 11/25/2025, the P&P indicated, If caregivers are to prevent falls, they must first have a working knowledge of the key factors that determine which residents are most at risk. History of falls. Any information about previous falls should be reported immediately to the charge nurse. Important details include the specific activity the resident was doing at the time of the fail, any symptoms experienced just before or at the time of the fall, and any' injuries sustained. Medical treatment issues. Side effects from medications are a major cause if falls in the elderly.