

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

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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 06/05/2026
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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and record review, the facility staff failed to notify the physician immediately when a resident had decreased meal intake (consumed less than 50 percent of his meal) for one of five sampled residents (Resident 5). This deficient practice had the potential to negatively affect the provision of necessary care and services. Findings: During a review of Resident 5's admission Record, the admission Record indicated the facility admitted the resident on 10/8/2025 with diagnoses that included acute respiratory failure (sudden lack of oxygen to the lungs) unspecified whether with hypoxia (body tissues and organs not getting enough oxygen) or hypercapnia (buildup of too much carbon dioxide), aphasia (a disorder that makes it difficult to speak), and person injured in other specified non collision transport accidents involving motor vehicle (traffic), subsequent encounter During a review of Resident 5's Minimum Data Set (MDS- a resident assessment tool) dated 5/4/2026, the MDS indicated that Resident 5 had severely impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses), and dependent on staff with toileting hygiene, tub/shower transfer, lower body dressing, roll left and right, and chair/bed to chair transfer. During a review of Resident 5's Nutritional Eaten Percentage Amount, Nutritional Eaten Percentage Amount indicated that Resident 5's meal percentage was 40% on 5/16/2026 at 1:00 p.m., 40% on 5/17/2026 at 1:00 p.m., and 20% on 5/17/2026 at 1:00 p.m. During an interview on 6/3/2026 at 12:45 p.m., with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated that CNA 4 had reported to him (LVN 2) that Resident 5's Nutritional Eaten Percentage Amount on 5/16/2026 at 1:00 p.m., 5/17/2026 at 1:00 p.m., and 5/18/2026 at 1:00 p.m., were less than 50% of his meal. LVN 2 stated he should have completed a change of condition, and by not completing a change of condition it can negatively affect and delay in providing the necessary care and services that Resident 5 needs. During an interview on 6/3/2026 at 2:51 p.m., with the Registered Dietician (RD), the RD stated she (RD) was not aware that Resident 5's meal percentage was 40% on 5/16/2026 at 1:00 p.m., 40% on 5/17/2026 at 1:00 p.m., and 20% on 5/17/2026 at 1:00 p.m. The RD stated if she was aware of Resident 5's meal intake, she would have provided additional recommendations for Resident 5's weight management. During an interview on 6/5/2026 at 3:30 p.m., with Assistant Director of Nursing 1 (ADON1), ADON 1 stated that the nurses should have done a change of condition for Resident 5 because it can negatively affect and delay providing the necessary care and services that the resident needs. During a review of the facility's policy and procedure titled, Change of Condition, last reviewed on 11/25/2025, the policy indicated all changes of condition in a resident shall be handled promptly. Upon a change of condition for any reason, nursing staff members are to take the following actions. Physician shall be called promptly. Documentation of change of condition shall be performed by the Licensed Nurse accordingly.		

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 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure History and Physical (H&P- contains relevant information about the resident's past medical history, current medical concerns, including review of any pre-existing medical conditions, past hospitalizations and surgeries, allergies, medications being taken, family medical history, physical examination and assessment of mental status) Examinations were completed by the physician for two of five sampled residents (Resident 4 and Resident 5). This deficient practice had the potential to result in incomplete clinical information, inconsistent care coordination, and compromised continuity of care, placing Resident 4 and Resident 5 at risk for unmet care needs and inadequate treatment planning. Findings: a. During a review of Resident 4's admission Record, the admission Record indicated the facility initially admitted the resident on 4/2/2026 with diagnoses that include encephalopathy (a brain disease, damage, or malfunction), acute respiratory failure (sudden lack of oxygen to the lungs) with hypoxia (body tissues and organs not getting enough oxygen), and cerebral infarction (lack of blood flow resulting in severe damage to some of the brain tissue). During a review of Resident 4's Minimum Data Set (MDS- a resident assessment tool) dated 4/16/2026, the MDS indicated that Resident 4 had severely impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses), and dependent on staff with toileting hygiene, tub/shower transfer, lower body dressing, roll left and right, and chair/bed to chair transfer. During a review of Resident 4's H&P dated 4/23/2026, the H&P indicated there was no documented evidence that Resident 4's physician completed and documented an assessment of Resident 4's mental status (assessment of current mental capacity [ability to understand and make decisions]). b. During a review of Resident 5's admission Record, the admission Record indicated the facility admitted the resident on 10/8/2025 with diagnoses that included acute respiratory failure (sudden lack of oxygen to the lungs) unspecified whether with hypoxia (body tissues and organs not getting enough oxygen) or hypercapnia (buildup of too much carbon dioxide), aphasia (a disorder that makes it difficult to speak), and person injured in other specified non collision transport accidents involving motor vehicle (traffic), subsequent encounter. During a review of Resident 5's MDS dated [DATE], the MDS indicated that Resident 5 had severely impaired cognition and dependent on staff with toileting hygiene, tub/shower transfer, lower body dressing, roll left and right, and chair/bed to chair transfer. During a review of Resident 5's H&P dated 4/28/2026, the H&P indicated there was no documented evidence that Resident 5's physician completed and documented an assessment of Resident 5's mental status. During a concurrent interview and record review on 6/5/2026 at 3:45 p.m., with Assistant Director of Nursing 1 (ADON 1), reviewed Resident 4's H&P dated 4/23/2026 and Resident 5's H&P dated 4/28/2026. ADON 1 stated Resident 4's H&P dated 4/23/2025 was incomplete because Resident 4's physician failed to document Resident 4's mental status assessment, which is necessary to establish a baseline for care planning. ADON 1 further stated Resident 5's H&P dated 4/28/2026 was incomplete because the physician failed to document the resident's mental status assessment, which is an important component in developing and implementing an appropriate plan of care. During a review of the facility's policy and procedure (P&P) titled, Physician Services, last reviewed on 11/25/2025, the P&P indicated the medical care of each resident is supervised by a licensed physician. Supervising the medical care of residents includes (but is not limited to): participating in the residents' assessment and care planning and overseeing a relevant plan of care.		