

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

Printed: 10/09/2026
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 07/28/2026
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure that the environment remained as free of accident hazards as possible for one of three sampled residents (Resident 1) when Resident 1's bed was left unattended in the raised position. This failure had the potential to increase Resident 1's risk of falling or injury. Findings: During a review of Resident 1's Face Sheet, the Face Sheet indicated that the facility admitted the resident on 11/8/2008 and readmitted the resident on 9/5/2024 with diagnoses including an unspecified head injury, anoxic brain damage (injury caused by lack of oxygen to the brain), and epilepsy (a brain disorder that causes repeated, unprovoked seizures [a sudden, abnormal surge of electrical activity in the brain that temporarily changes how a person acts, moves, feels, or is aware]). During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool) dated 6/22/2026, the MDS indicated that Resident 1 was dependent on caregivers for all daily activity, including bathing, toileting, and dressing, and has limited range of motion (a joint or body part cannot move fully or easily through its normal distance and direction) in all four limbs. During a review of Resident 1's History and Physical (H&P) dated 7/3/2026, the H&P indicated Resident 1 had cognitive (mental process of acquiring, storing, and using knowledge) impairment. During a review of Resident 1's Care Plan, last reviewed 6/30/2026, the care plan indicated that Resident 1 is at risk for falls and injury related to impaired cognition, poor body balance and control, poor safety awareness and judgement, seizure disorder, and general weakness. The care plan indicated that Resident 1 had a history of falls. The care plan also indicated that floor mats and padded side rails were used to prevent or reduce injury and falls. During an observation on 7/28/2026 at 12:15 p.m., in Resident 1's room, observed Certified Nursing Assistant 1 (CNA 1) leave Resident 1's bed raised after working with Resident 1 and then left the room and did not return. During a concurrent observation and interview on 7/28/2026 at 12:25 p.m., with Licensed Vocational Nurse 1 (LVN 1) in Resident 1's room, observed Resident 1's bed. LVN 1 stated that Resident 1's bed was not in the low position. LVN 1 stated that the bed should be in the low position for safety reasons, but that Resident 1 wasn't at risk for a fall since padded railing were in place. LVN 1 left Resident 1's bed in raised position after leaving the room. During a concurrent observation and interview on 7/28/2026 at 12:35 p.m., with Director of Staff Development 1 (DSD 1) outside Resident 1's room, DSD 1 entered Resident 1's room and lowered the bed to the low position. DSD 1 stated that Resident 1's bed should be kept in the lowest position as part of standard fall precautions to prevent injury. DSD 1 stated that although there were padded railings on Resident 1's bed, all safety measures should be taken. During an interview on 7/28/2026 at 2:36 p.m., with Registered Nurse 1 (RN 1), RN 1 stated that keeping the bed in the lowest position was a standard part of fall prevention. During an interview on 7/28/2026 at 3:25 p.m., with the Assistant Director of Nursing (ADON), the ADON stated that standard fall precaution interventions include raised side rails, keeping bed in the low position, using a floor mat (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 - Few	next to the bed, and responding quickly to call lights. The ADON stated that if a bed was left in the raised position, there was a risk of falls. During a review of the facility's policy and procedure titled, Promoting Safety, Reducing Falls, undated, the policy indicated, Caregivers should always make sure that beds are in the lowest position to the floor and that wheels are locked.		