STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056180	A. Building B. Wing	01/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Balboa Care Center	16955 Vanowen Street Van Nuys, CA 91406

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on interview and record review, the facility failed to ensure one of three sampled resident's (Resident 1) confidential personal information was protected when a copy of Resident 1's Discharge Summary and Post-Discharge Plan of Care was given to Resident 2. This deficient practice violated Resident 1's rights and resulted in the unauthorized exposure of Resident 1's confidential information.Findings: During a review of Resident 1's admission Record, the admission Record indicated the facility originally admitted the resident on 10/22/2025 and readmitted the resident on 11/13/2025 with diagnoses that included sepsis (a potentially life-threatening condition that occurs when the body's extreme response to an infection causes injury to its own tissues and organs), Non-Hodgkin lymphoma (a type of blood cancer originating in white blood cells within the immune system, often causing swollen lymph nodes, fever, night sweats, and weight loss), and hypotension (low blood pressure). During a review of Resident 1's Admitting Evaluation History and Physical dated 11/14/2025, the Admitting Evaluation History and Physical indicated Resident 1 had fluctuating capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 11/19/2025, the MDS indicated Resident 1 had severely impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). During a review of Resident 1's Discharge Summary and Post-Discharge Plan of Care dated 12/23/2025, the Discharge Summary and Post-Discharge Plan of Care contained the following information:- Resident 1's full name, date of birth , and dates of admission to the facility.- A recapitulation of Resident 1's stay that included the reason for admission, treatment provided, discharge date , reason for discharge, and final diagnosis.- The final summary of Resident 1's status that included cognitive status, physical function, nutritional status, and Resident 1's height and weight.- The post discharge plan of care that included Resident 1's home address, phone number, physician name and phone number, home health agency name and phone number, and medical equipment ordered. During a review of a facility letter sent to Resident 1 dated 12/31/2025, the facility letter indicated that on 12/24/25, the facility was made aware that Resident 1's discharge summary and discharge plan of care was mistakenly given to another discharging resident. The facility letter further indicated the information included Resident 1's full name, date of birth , admission date, address, discharge date , diagnosis, phone number, reason for admission to the facility, physician order for home health, height, weight, and reason for discharge. During an interview on 1/26/2026 at 9:50 a.m., with the Patient Concierge (PC), the PC stated on 12/24/2025 she received a phone call from Resident 2's husband. The PC stated that Resident 2's husband called to inform her (PC) that Resident 1's discharge papers were included with Resident 2's discharge paperwork. The PC stated she immediately reported the information to the medical records department. During an interview on 1/26/2026 at 10:08 a.m., with the Medical Records Assistant (MRA), the MRA stated that on 12/24/2025 she was informed by the PC that Resident 1's discharge paperwork was accidentally given to Resident 2. The MRA stated the medical records department does not print the (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	discharge paperwork for discharges, the nurses print the discharge paperwork themselves. During an interview on 1/26/2026 at 10:50 a.m., with the Infection Prevention Nurse (IP), the IP stated that on 12/24/2025 she was working as the Registered Nurse (RN) supervisor for the 7:00 a.m. to 3:00 p.m. shift because the RN supervisor who was supposed to work that shift had called off. The IP stated part of her job duties that day included discharging several residents. The IP stated that the night shift usually prepares and prints out the discharge paperwork for the discharges scheduled for the following day and will place the printed discharge papers in the residents' physical charts. The IP stated when she was discharging Resident 2, she pulled out the discharge papers from Resident 2's physical chart and only reviewed the first few pages and ensured that the face sheet and medication list matched Resident 2's name. The IP stated she did not check all of the pages of the discharge paperwork and was unaware that Resident 1's discharge paperwork was part of the paperwork given to Resident 2. The IP stated she should have reviewed each document carefully to ensure the right documents were given to the right resident. The IP stated that by accidentally giving Resident 1's discharge paperwork to Resident 2, she violated patient confidentiality and disclosed Resident 1's private health information to Resident 2. During an interview on 1/26/2026 at 11:16 a.m., with the Director of Nursing (DON), the DON stated the IP accidentally included Resident 1's Discharge Summary and Post-Discharge Plan of Care with Resident 2's discharge paperwork. The DON stated that the IP should have checked every document to ensure all of the documents being provided to Resident 2 were actually for Resident 2. The DON stated that giving Resident 1's Discharge Summary and Post-Discharge Plan of Care to Resident 2 was a Health Insurance Portability and Accountability Act (HIPAA - a federal law designed to protect the privacy and security of patient health information) violation. During a review of the facility's undated policy and procedure titled, Resident/Patient Confidentiality, the policy indicated it is the policy of the facility to ensure all resident health information is confidential and protected by HIPAA Law. The policy and procedure further indicated all staff, volunteers, and vendors must not disclose any medical information about a resident, either verbally, written or electronically and that only legal authorization allows any medical information to be released.