| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056180 | A. Building<br>B. Wing | 03/12/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Lake Balboa Care Center | 16955 Vanowen Street<br>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) |
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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the facility's Registered Dietitians (RD) conducted a nutrition-focused physical assessment (a physical exam that RDs perform to assess nutritional status or evaluate malnutrition [lack of sufficient nutrients in the body]) by not speaking to residents or residents' family members/representatives and by not physically assessing residents during the Nutrition Evaluation and Registered Dietician Nutritionist (RDN) Review for two of three sampled residents (Resident 1 and Resident 2). This failure had the potential to result in inaccurate nutrition assessments, and ineffective nutrition intervention and goals for Resident 1 and Resident 2 who are on hemodialysis (a life-saving medical procedure that filters waste, toxins, and excess fluid from the blood when kidneys [organs located in the lower back that act as the body's primary filtration system] have failed).Findings: a. During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 10/29/2025 with diagnoses that included end stage renal disease (ESRD- kidneys have severely deteriorated and can no longer function adequately to filter waste products and excess fluid from the blood), type two (2) diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), moderate protein- calorie malnutrition (a nutritional disorder occurring when a person does not consume enough protein and calories to meet their body's needs), and dependence on renal dialysis (hemodialysis- a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 11/4/2025, the MDS indicated Resident 1's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the sense) was moderately impaired. The MDS indicated Resident 1 required set up or clean up assistance from staff with eating, required supervision or touching assistance with oral hygiene and personal hygiene, and required substantial/maximal assistance with toileting hygiene. During a review of Resident 1's care plan (a document that summarizes a resident's needs, goals, and care/treatment) for risk for nutrition problem or potential nutritional problem related to chronic kidney disease (kidneys are damaged and gradually lose their ability to filter waste and extra fluid from your blood over a long period, usually months or years) with hemodialysis, ESRD, DM, and moderate protein-calorie malnutrition, initiated on 10/29/2025, the care plan indicated an intervention for the Registered Dietician (RD) to evaluate and make diet change recommendations as needed (PRN). During a concurrent interview and record review on 3/11/2026 at 2:50 p.m., with the Dietary Supervisor (DS), reviewed Resident 1's Nutrition Evaluation and Registered Dietician Nutritionist (RDN) Review dated 10/31/2025 timed at 8:57 a.m. The DS stated that residents' dietary evaluations are done within seven days of admission. The DS stated that the Nutrition Evaluation is conducted in two parts. The DS stated that within the first three days of the resident's admission, the DS will interview the resident to obtain the resident's food likes and dislikes, allergies, and what residents prefer for breakfast, lunch, and dinner. The second part of the evaluation is when the Registered Dietician does their part of the evaluation and writes their recommendations based on the information gathered by the DS. The DS reviewed Resident 1's Nutrition Evaluation and RDN Review dated<br>(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 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 10/31/2025 timed at 8:57 a.m. and stated that the DS performed the Dietary Evaluation portion and Registered Dietician 1 (RD 1) conducted the RDN Nutritional Assessment/Evaluation portion of the review. The DS stated that RD 1 does not meet and speak with the residents to perform a nutrition focused physical assessment. During an interview on 3/12/2026 at 10:25 a.m., with RD 1, RD 1 stated that she is one of the contracted RDs of the facility. RD 1 stated that she conducts her assessments through a thorough chart review reviewing residents' diagnosis, orders, medication, lab results, oral intake, height and weight. RD 1 stated that she does not enter the facility because she works remotely. RD 1 stated that RD 2 is the RD that visits the facility every Thursday. RD 1 continued to state that RD 1 does not perform nutrition focused physical assessments with the residents in the facility and that RD 1 conducts her assessments and evaluations based on the information gathered by the DS since the DS meets and speaks to the residents. RD 1 stated that she does not speak to the residents or residents' family nor does she physically see residents in the facility. RD 1 further stated that RD 1's assessment and evaluations are solely based on record review. b. During a review of Resident 2's admission Record, the admission Record indicated the facility admitted Resident 2 on 2/27/2026 with diagnoses that included ESRD, DM, and dependence on renal dialysis. During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2's cognition was moderately impaired. The MDS indicated Resident 2 required set up or clean up assistance from staff with eating, required supervision or touching assistance with oral hygiene, and required substantial/maximal assistance with toileting hygiene. During a review of Resident 2's care plan for nutrition problem or potential nutritional problem related to diabetes and chronic kidney disease with hemodialysis, revised on 3/10/2026, the care plan indicated an interventions for the RD to evaluate and make diet change recommendations PRN. During an interview on 3/12/2026 at 11:22 a.m., with the Administrator (ADM), the ADM stated that the facility's RDs are contracted and RD 2 is the RD that comes to the facility every Thursday. During a follow-up interview on 3/12/2026 at 12:11 p.m., with RD 1, RD 1 stated that she (RD 1) does not come into the facility to conduct nutritional-focused physical assessments because RD 1's contract indicates that she is to do remote work only. RD 1 stated that RD 2 goes into the facility every week and if the facility needs a registered dietician, the DS is in the facility to inform RD 1 or RD 2 of any concerns. RD 1 continued to state that a face-to-face nutrition-focused physical assessment is not necessary because RD 1 goes through nursing notes, lab results, and oral intake which gives RD 1 an overall picture of the resident. RD 1 stated that it will not make a difference whether RD 1 is in the facility or working remotely. RD 1 continued to state that during a record review of residents' medical records, if there is anything that concerns RD 1, she will inform RD 2 or the DS so that RD 2 or the DS can check on it. When asked if RD 1 should check on concerns herself, RD 1 stated that it is not necessary because there are people there in the facility to check for her. During a concurrent interview and record review on 3/12/2026 at 3:03 p.m., with RD 2, reviewed Resident 2's Nutrition Evaluation and RDN Review dated 2/28/2026 timed at 12:41 p.m. RD 2 stated that she (RD 2) is a contracted RD that comes into the facility every Thursday. RD 2 stated on Thursdays when RD 2 arrives at the facility she will receive a list of new admissions. RD 2 stated that she will go through the list of new admissions and will prioritize high risk residents such as residents on tube feeding (a form of nutrition that is delivered into the digestive system as a liquid) or on dialysis. RD 2 stated that she does a thorough record review of the residents' medical record, reviewing residents' diets, lab results, medical diagnosis, any weight gain or weight loss and RD 2 will discuss with the Interdisciplinary Team (IDT- a group of healthcare professionals from different disciplines who work together to plan and provide care for a resident) to come up with a suitable plan for the resident. RD 2 continued to state that residents in the facility do not stay long term anyway and it is not necessary for RD 2 to do a face-to-face assessment with the residents. RD 2 stated that the DS is there five days per week, and if there are any concerns that the DS cannot address then the DS reports to RD 1 or RD 2. When asked how RD 1 is able to do an assessment remotely, RD 2 stated that RD 1 knows exactly what RD 1 is doing because she is highly<br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | educated and she does not need to do a face-to-face assessment. RD 2 reviewed Resident 2's Nutrition Evaluation and RDN Review dated 2/28/2026 timed at 12:41 p.m. RD 2 stated that Resident 2 is on dialysis and should have been seen and evaluated by RD 2. When asked if RD 2 has seen and assessed Resident 2, RD 2 stated that RD 2 has not assessed Resident 2 because Resident 2 is on dialysis every Tuesday, Thursday, and Saturday and when RD 2 is at the facility on Thursdays, Resident 2 is not in the facility. When asked if Resident 2 will be seen by RD 2 because Resident 2 is a high risk resident on dialysis, RD 2 did not answer. RD 2 stated that RD 1 assessed Resident 2 and documented on the Nutrition Evaluation and RDN Review dated 2/28/2026. When asked about the standards of practice of a registered dietitian and what entails a nutrition-focused physical assessment, RD 2 did not answer. During an interview on 3/12/2026 at 3:51 p.m., with the Director of Nursing (DON), the DON stated that RD 1 works remotely and RD 2 comes to the facility every Thursday. The DON stated that RD 2 is expected to check on and assess newly admitted residents. The DON stated that ideally an assessment should be done in person to get the best clinical picture of the resident. The DON continued to state that residents in the facility are short term residents and they don't have too many health problems, so for the DON it is ok that RD 1 assesses residents remotely through a thorough record review. During a follow-up interview on 3/12/2026 at 4:30 p.m., with the DS, the DS stated that it is important to conduct a nutrition-focused physical assessment because is important for the RD to see how a resident eats, how the resident chews, observes skin integrity, and to give the RD an overall clinical picture of the residents. During a review of the facility's policy and procedure (P&P) titled, Nutrition Care Management, reviewed 2/17/2026, the P&P indicated under purpose: to provide care and services including assessing the resident's nutritional status and the factors that put the resident at nutrition/hydration risk; Defining and implementing interventions for maintaining or improving nutritional hydration status that are consistent with resident needs, goals, and recognized standards of practice. Under Clinical Evaluation.: 1. Nutritional Assessment may include: Functional status (assistive devices, cues, hand-overhand, extensive assistance); Oral health (oral cavity lesions, mouth pain, decayed teeth, poorly fitting dentures); Chewing and swallowing problems; Affective and behavioral disorders; Hypermetabolic states (continuous wandering, skin breakdown) During a review of the facility's job description titled, Dietician, dated 12/27/2021, the job description indicated the primary purpose of the job description position is to plan organize develop and direct the overall operation of the dietary department in accordance with current federal state and local standards guidelines and regulations governing the facility and as may be directed by the administrator to assure that quality nutritional services are provided on a daily basis and that the dietary department is maintained in a clean safe and sanitary manner. Visit residents periodically to evaluate the quality of meals served, likes and dislikes, etc. Encourage the resident/family to participate in the development and review of residents plan of care. During a review of the facility's contract with the Registered Dieticians titled, Independent Service Agreement, dated 2/19/2025, the contract indicated service provider will prepare complete records of all services with complete, legible, and accurate progress notes and observations in accordance with the requirements of all applicable federal and state agency requirements and by Facility policies and procedures. During a review of the Academy of Nutrition and Dietetics' Nutrition Care Process titled, NCP Step 1: Nutrition Assessment, the document indicated, Nutrition assessment is a systematic approach to collect, classify, and synthesize important and relevant data (indicator) needed to identify nutrition-related problem and their causes. This step also includes reassessment for comparing and re-evaluating data from previous interaction to the next and collection of new data that may lead to new revised nutrition diagnoses based on the client status or situation. Finding Nutrition Assessment Data: For individuals, data can come directly from the client through interview, observation and measurements, a health record, and the referring health care provider. During a review of the Academy of Nutrition and Dietetics' Nutrition Care Process titled, NCP Step 3: Nutrition Intervention, the document indicated, Nutrition intervention goals, ideally, developed collaboratively<br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | with the client, provide the basis for monitoring progress and measuring outcomes. Planning the nutrition intervention involves: Collaborating with the client to identify goals of the intervention for each diagnosis. Implementation is the action phase and involves: Collaborating with the client to carry out the plan of care. During a review of the Academy of Nutrition and Dietetics' Nutrition Care Process titled, NCP Step 4: Nutrition Monitoring and Evaluation, undated, the document indicated, During the first interaction, appropriate outcomes/indicators are selected to be monitored and evaluated at the next interaction with the client. During subsequent interactions, these outcomes /indicators are used to demonstrate the amount of progress made and whether the goals or expected outcomes are being met. |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement the facility's policy on intake and output (I &O- the tracking of all fluids that enter (intake) and leave (output) a resident's body over a set period, usually 24 hours) by failing to monitor and ensure residents on fluid restrictions (a medically prescribed diet limiting total daily liquid consumption) did not exceed their fluid restriction volume for two of three sampled residents (Resident 2 and resident 3). This deficient practice had the potential to cause fluid overload (condition where you have too much fluid volume in your body) for Resident 2 and Resident 3. Findings: a. During a review of Resident 2's admission Record, the admission Record indicated the facility admitted Resident 2 on 2/27/2026 with diagnoses that included end stage renal disease (kidneys have severely deteriorated and can no longer function adequately to filter waste products and excess fluid from the blood), type two (2) diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), and dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed). During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool) dated 3/5/2026, the MDS indicated Resident 2's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the sense) was moderately impaired. The MDS indicated Resident 2 required set up or clean up assistance from staff with eating, required supervision or touching assistance with oral hygiene, and required substantial/maximal assistance with toileting hygiene. During a review of Resident 2's Order Summary Report, the Order Summary Report indicated an order for 1,500 milliliters (mL- unit of measurement) fluid restrictions. Breakdown as follows: AM/ Nursing: 360 mL; AM/ Dietary: 240 mL; PM/ Nursing: 360 mL; Lunch Meal Dietary: 120 mL; Noc (11:00 p.m.-7:00 a.m.)/ Nursing: 180 mL; Dinner/ Dietary: 240 mL, order date 2/27/2026. During a review of Resident 2's care plan (CP-a document that summarizes a resident's needs, goals, and care/treatment) for dialysis, revised on 3/10/2026, the CP indicated under intervention for 1,500 mL fluid restrictions. Breakdown as follows: AM/ Nursing: 360 mL; AM/ Dietary: 240 mL; PM/ Nursing: 360 mL; Lunch Meal Dietary: 120 mL; Noc/ Nursing: 180 mL; Dinner/ Dietary: 240 mL, order date 2/27/2026. During a concurrent interview and record review on 3/12/2026 at 9:00 a.m., with the Assistant Director of Nursing (ADON), reviewed Resident 2's physician's orders, Resident 2's CNA fluid intake documentation from 3/1/2026-3/11/2026, and Resident 2's Intake and Output Record from 3/1/2026-3/11/2026. The ADON stated that when residents are on fluid restrictions, licensed nurses and Certified Nursing Assistants (CNAs) will monitor all fluids consumed by residents. The ADON stated the licensed nurses will document residents' fluid consumption that the licensed nurses provided on an Intake & Output Record and CNAs will document fluids that CNAs provided on the CNA tasks, under fluid intake on the electronic health record. The ADON stated that fluids given by both licensed nurses and CNAs should be added together at the end of each shift and should be equal to or less than the amount of the fluid restriction in a 24-hour period. The ADON reviewed Resident 2's physician's orders and stated that Resident 2 is on a 1,500 mL fluid restriction daily. The ADON reviewed Resident 2's CNA fluid intake documentation from 3/1/2026-3/11/2026 and stated that on the following days Resident 2 received the following mLs of fluid from CNAs:- 3/1/2026: 1,800 mL- 3/2/2026: 1,300 mL- 3/3/2026: 1,100 mL- 3/4/2026: 920 mL- 3/5/2026: 1,350 mL- 3/6/2026: 550 mL- 3/7/2026: 1,400 mL- 3/8/2026: 1,850 mL- 3/9/2026: 2,200 mL- 3/10/2026: 1,180 mL- 3/11/2026: 915 mLThe ADON reviewed Resident 2's Intake and Output Record from 3/1/2026-3/11/2026 and stated that on the following days Resident 2 received the following mLs of fluid from licensed nurses:- 3/1/2026: 1,300 mL- 3/2/2026: 1,300 mL- 3/3/2026: 850 mL- 3/4/2026: 1,400 mL- 3/5/2026: 800 mL- 3/6/2026: 1,100 mL- 3/7/2026: 850 mL- 3/8/2026: 850 mL- 3/9/2026: 1,100 mL- 3/10/2026: 980 mL- 3/11/2026: 1,100 mLThe ADON stated that in a 24-hour period Resident 2 received a total of:- 3,100<br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | mL on 3/1/2026.- 2,600 mL on 3/2/2026.- 1,950 mL on 3/3/2026.- 2,320 mL on 3/4/2026.- 2,150 mL on 3/5/2026.- 1,650 mL on 3/6/2026.- 2,250 mL on 3/7/2026.- 2,700 mL on 3/8/2026.- 3,300 mL on 3/9/2026.- 2,160 mL on 3/10/2026.- 2,015 mL on 3/11/2026. During a follow-up interview on 3/12/2026 at 9:46 a.m., with the ADON, the ADON stated that fluids provided by licensed nurses and from the kitchen should be the only fluids offered to residents on fluid restrictions. The ADON continued to state that CNAs should be informing license nurses prior to offering or providing fluids to residents with fluid restrictions for proper monitoring. The ADON stated that the facility failed to monitor Resident 2's intake per physician's order. The ADON further stated that licensed nurses should be communicating with one another, especially during huddle to remind CNAs on which residents are on fluid restrictions to accurately monitor fluid intake. b. During a review of Resident 3's admission Record, the admission Record indicated the facility admitted Resident 3 on 2/3/2026 with diagnoses that included but not limited to end stage renal disease, dependence on renal dialysis, and hypertension (high blood pressure [the force of the blood pushing on the blood vessel walls is too high]). During a review of Resident 3's Minimum Data Set, dated [DATE], the MDS indicated Resident 3 had moderately intact cognitive skills for daily decision making. The MDS indicated Resident 3 required supervision with oral hygiene and partial/moderate assistance with personal hygiene and substantial/maximal assistance with toileting and showering. During a review of Resident 3's Order Summary Report, active as of 3/11/2026, the Order Summary Report indicated an order for 1,000 mL fluid restriction broken down into breakfast, lunch, and dinner. During a review of Resident 3's CP, initiated 2/27/2026, the CP indicated Resident 3 was on dialysis related to ESRD. The CP indicated an intervention for 1,000 mL fluid restriction broken down into breakfast, lunch, and dinner. During a review of Resident 3's Dietary Evaluation dated 2/6/2026, the Dietary Evaluation indicated Resident 3 was on fluid restriction of 1,000 mL broken down into breakfast, lunch, and dinner and that Resident 3's PO (by mouth) intakes were monitored. During a review of Resident 3's CNA tasks dated 2/11/2026 to 3/11/2026, the CNA tasks indicated Resident 3's daily fluid intake was over the 1,000 mL fluid restriction on the following dates:- On 2/12/2026, total of 1,150 mL- On 2/13/2026, total of 1,100 mL- On 2/14/2026, total of 1,050 mL- On 2/17/2026, total of 1,200 mL- On 2/18/2026, total of 1,050 mL- On 2/19/2026, total of 1,150 mL- On 2/20/2026, total of 1,050 mL- On 3/2/2026, total of 1,220 mL- On 3/5/2026, total of 1,050 mL During a concurrent interview and record review on 3/12/2026 at 2:03 p.m., with the ADON, reviewed Resident 3's CNA fluid intake record from 2/11/2026 to 3/11/2026. The ADON stated that Resident 3 received more fluids than Resident 3 should have consumed on 2/12/2026, 2/13/2026, 2/14/2026, 2/17/2026, 2/18/2026, 2/19/2026, 2/20/2026, 3/2/2026, and 3/5/2026. The ADON stated licensed nurses should have monitored Resident 3's fluid intake to not exceed 1,000 ml. The ADON stated that it is important to ensure all residents on fluids restrictions are monitored to ensure complications do not happen such as shortness of breath and fluid overload, and to avoid unwanted transfers to the hospital. The ADON stated proper monitoring, and documentation should have been done. During a review of the facility's policy & procedure (P&P) titled, Intake and Output, reviewed 2/17/2026, the P&P indicated it is the policy of this facility to maintain an intake and output record when needed to monitor residents for adequate fluid balance intake and output shall be recorded by each shift. Purpose: to provide an accurate record of the resident's fluid intake and output. Measuring Intake: Place daily I & O sheet in resident's room. Nursing assistants will document fluids (in cubic centimeters [cc- unit of measurement]) consumed in appropriate area of I & O sheet for each shift. Monitor and record fluid from diet trays and from water pitcher at bedside. Licensed staff will document all fluids (in cc's) consumed by resident while taking medications in the I & O sheet. Documentation: 3-11 shift will collect all I & O sheets at the end of shift and replace with a new one for the next day. Data recorded on the I & O sheets from the bedside will be recorded on the resident's permanent I&O sheet in their medical record. Intake for a twenty-four (24) hour period shall be totaled by the 3-11 shift each day. |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0806<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.<br><br>Based on observation, interview, and record review, the facility failed to provide one of three sampled residents (Resident 2) with meals that accommodated their food preferences. This deficient practice resulted in Resident 2's food preferences not being honored and had the potential to result in decreased meal intake which could lead to weight loss and malnutrition (lack of sufficient nutrients in the body).Findings: During a review of Resident 2's admission Record, the admission Record indicated the facility admitted Resident 2 on 2/27/2026 with diagnoses that included end stage renal disease (kidneys have severely deteriorated and can no longer function adequately to filter waste products and excess fluid from the blood), type two (2) diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed). During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool) dated 3/5/2026, the MDS indicated Resident 2's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and sense) was moderately impaired. The MDS indicated Resident 2 required set up or clean up assistance from staff with eating, required supervision or touching assistance with oral hygiene, and required substantial/maximal assistance with toileting hygiene. During a review of Resident 2's Order Summary Report, the Order Summary Report indicated an order for consistent carbohydrate diet (CCHO - helps control blood sugar levels)/renal diet (designed for individuals with chronic kidney disease [a condition where the kidneys gradually lose their ability to filter waste products and excess fluid from the blood]) regular/thin liquid consistency with meals, ordered 2/27/2026. During a review of Resident 2's care plan (a document that summarizes a resident's needs, goals, and care/treatment) for nutrition problem or potential nutritional problem related to diabetes and chronic kidney disease with hemodialysis, revised on 3/10/2026, the care plan indicated an intervention to honor resident rights to make personal dietary choices. During a review of Resident 2's meal card, the meal card indicated added food for lunch: soup. During a review of Resident 2's Nutrition Evaluation and Registered Dietician Nutritionist (RDN) Review dated 2/28/2026 timed 12:41 p.m., the Nutrition Evaluation and RDN Review indicated under preference, Resident 2 likes soup for lunch. During a concurrent observation, interview, and record review on 3/11/2026 at 12:48 p.m., with the Director of Nursing (DON) in Resident 2's Room, observed Resident 2's lunch tray. The DON stated that Resident 2 does not have soup served. The DON reviewed Resident 2's meal card and stated that Resident 2 should have soup served because Resident 2's meal card indicated that Resident 2 should have soup for lunch. During an interview on 3/12/2026 at 2:50 p.m. with the Dietary Supervisor (DS), the DS stated that kitchen staff are supposed to follow what is on residents' meal tickets at all times. The DS stated it is important to follow what is on residents' meal tickets because kitchen staff need to follow and honor residents' preferences and choices. The DS continued to state that the facility failed to honor Resident 2's food preference by failing to serve Resident 2's soup during lunch. The DS continued to state that by not serving Resident 2's preference of soup, the kitchen staff did not honor Resident 2's rights. During a review of the facility's policy and procedure (P&P) titled, Food Preferences, last reviewed 2/17/2026, the P&P indicated resident's food preferences will be adhered to within reason. Food preferences will be obtained as soon as possible through the initial resident screen. The screening must be completed within seven (7) days of admission by the Food & Nutrition Service (FNS) Director. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056180 | A. Building<br>B. Wing | 03/12/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Lake Balboa Care Center | 16955 Vanowen Street<br>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 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, interview, and record review, the facility failed to follow proper food handling and storage practices by failing to ensure: 1. A clear plastic bag containing a cup of food brought by family member for a resident was labeled with a date for when it was brought into the facility. 2. A clear plastic container of strawberries did not have visible black/green discoloration consistent with mold-like (type of fungus) substance present on several strawberries stored inside one of three sampled refrigerators (Refrigerator 2). 3. An opened package of hamburger buns was labeled with an open date stored inside one of three sampled refrigerators (Refrigerator 3).These deficient practices had the potential to place 45 of 45 residents who receive food from the facility's kitchen at risk for foodborne illnesses (refers to illness caused by the ingestion of contaminated food or beverages).Findings: During a concurrent observation and interview on 3/11/2026 at 10:00 a.m., with the Dietary Supervisor (DS), observed the following in the facility' s kitchen: - An undated clear plastic bag containing a cup for food brought by family, labeled with a resident's room number stored on the bottom shelf inside Refrigerator 2. - A clear plastic container of strawberries dated 2/27/2026 with visible black/green discoloration consistent with mold-like (type of fungus) substance present on several strawberries stored inside Refrigerator 2.- An opened package of hamburger buns without an open date indicated on the package stored inside Refrigerator 3.The DS stated that food brought for residents was being stored in a closed container inside Refrigerator 2. The DS stated food prepared and cooked by family members for residents was also being stored inside the refrigerator and should be discarded after 24 hours for the safety of the residents. The DS stated the strawberries were not checked for any spoilage or mold. The DS stated staff should check that food items are fresh and safe to use and if not, should be discarded. The DS stated the hamburger buns did not have an open date label and stated that food items should have an open date label to follow guidelines on when to use the food item by. During a review of the facility's policy and procedure (P&P) titled, Foods brought by family or visitor, revised 1/26/2024, the P&P indicated, Perishable prepared foods will be checked by the designee dietary staff and discarded after 24 hours of storage. Resident food shall be stored in the facility kitchen. Resident food stored in the facility kitchen will be easily distinguishable from facility food. All foods shall be labeled with the resident name, location and date. During a review of the facility's P&P titled, Storing Produce, undated, the P&P indicated, Check boxes of fruit and vegetables for rotten, spoiled items. Throw away spoiled items upon delivery. During a review of the facility's P&P titled, Labeling and dating of foods, undated, the P&P indicated, For foods that are commercially processed, ready to eat and intended to be stored cold greater than 24 hours will be marked with a use by date.The use by date signifies the date in which food must be consumed or discarded. |