

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  056253	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/03/2025
NAME OF PROVIDER OR SUPPLIER  Berkley Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  6600 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)
<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>(continued on next page)</p>

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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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to conduct a resident's nutritional assessment within seven (7) days upon readmission for one of four sampled residents (Resident 1), as per the facility's policy and procedure (P&amp;P). This deficient practice had the potential to place the resident at risk for undetected nutritional status and at risk for medical complications related to impaired nutrition. Findings: During a review of Resident 1's admission Record indicated the facility originally admitted the resident on 8/28/2025 and readmitted the resident on 11/27/2025 with diagnoses that included diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing), hypertension (high blood pressure [the force of the blood pushing on the blood vessel walls is too high]), gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), and anemia (a condition where the body does not have enough healthy red blood cells). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 9/3/2025, the MDS indicated Resident 1's cognition (mental action or process of acquiring knowledge and understanding through thought, experience, and senses) was severely impaired. The MDS further indicated that Resident 1 was dependent on staff for activities of daily living (ADLs - activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 1's physician orders, the physician orders indicated the following orders:- Transfer Resident 1 to General Acute Care Hospital 1 (GACH 1) due to abnormal laboratory results, ordered 9/5/2025 timed at 3:10 p.m.- Admit Resident 1 to the facility, ordered 9/10/2025 timed at 12:45 p.m. During a review of Resident 1's Weights and Vitals Summary, the Weight Summary indicated the following:- On 8/29/2025, Resident 1 weighed 103 pounds (lbs. - a unit of weight)- On 9/5/2025, Resident 1 weighed 98 lbs.- On 9/11/2025, Resident 1 weighed 98 lbs. During a concurrent interview and record review on 12/3/2025 at 10:20 a.m., with Registered Dietitian 1 (RD 1), reviewed Resident 1's Nutritional Risk Assessments (NRAs) dated 8/29/2025 and 9/22/2025, dietary progress notes from Resident 1's initial admission [DATE], and Resident 1's Weights and Vitals Summary. RD 1 stated Resident 1's first nutritional assessment was done on 8/29/2025, and the second nutritional assessment was done on 9/22/2025, and no other comprehensive nutritional assessments were done after reviewing the dietary notes. RD 1 stated that Resident 1 lost five (5) lbs. from 103 lbs. (measured on 8/29/2025) to 98 lbs. before being transferred to the hospital on 9/5/2025. RD 1 stated Resident 1 returned to the facility on 9/10/2025 with the same weight of 98 lbs. RD 1 stated in general, a nutritional assessment should be done within seven (7) days of admission and readmission, but Resident 1's nutritional assessment was done on the 12th day of readmission (readmitted on [DATE]; nutritional assessment was done on 9/22/2025). During a concurrent interview and record review on 12/3/2025 at 11:40 a.m., with the Director of Nursing (DON), reviewed Resident 1's NRAs dated 8/29/2025 and 9/22/2025, dietary progress notes from Resident 1's initial admission [DATE], and Resident 1's Weights and Vitals Summary. The DON stated that Resident 1 had a gastrostomy tube (G-tube - a soft tube placed through the belly wall directly into the stomach, creating a shortcut for food, fluids, and medicine when someone can't eat or drink normally through their mouth due to swallowing issues) and lost five (5) lbs. from 103 lbs. to 98 lbs. at the facility before being transferred to the hospital on 9/5/2025. The DON further stated that when Resident 1 returned to the facility, after five (5) days of hospitalization, on 9/10/2025, Resident 1 weighed 98 lbs. The DON stated that the comprehensive nutritional assessment should be done within seven (7) days of readmission to assess Resident 1's nutritional conditions, but it was not done in a timely manner and was done on the 12th day of readmission on [DATE]. During a review of the facility's P&amp;P titled, Nutrition &amp; Weight Management Policy, last reviewed 10/2025, the policy indicated, The facility provides care and services to each Resident to ensure the Resident maintains acceptable parameters of nutritional status in the context of his or her overall condition. A comprehensive nutritional assessment shall be completed by a Dietitian within seven (7) days of admission, annually, and upon significant change in condition. Follow up assessments be completed as needed. During a review of the facility's P&amp;P titled, Weight Change Protocol, last reviewed 6/2025, the policy indicated, The following criteria define weight changes significant or insidious weight changes: Slow and progressive weight change trending away from weight goal. This can refer to weekly or monthly weight. Five (5) lbs. weight loss or gain in one (1) month. The Facility RD will assess, nutritionally diagnosis, suggest interventions, monitor, and evaluate the success of the interventions within seven (7) days of admission or</p>		