STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056253	A. Building B. Wing	02/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Berkley Post-Acute	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)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide routine biologicals and pharmacy services including administering all drugs per physician's order in accordance with good nursing principles and practices by failing to administer Atorvastatin (medication to help lower cholesterol) and Semglee (glargine insulin [a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication]) on 1/6/2026 at 9:00 p.m. per physician's order for one of three sampled residents. (Resident 1)This deficient practice had the potential to result in health complications due to inconsistent medication levels, leading to decreased therapeutic benefit.Findings: During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 to the facility on 1/6/2026 with diagnoses that included type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness of the arm, leg, and trunk on the same side of the body following cerebral infarction (CVA-stroke, loss of blood flow to a part of the brain) affecting right dominant side, and unspecified glaucoma (an eye condition that damages the optic nerve [a bundle of over a million nerve fibers that acts as a communication cable, transmitting visual information from the back of the eye to the brain]). During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool) dated 1/12/2026, the MDS indicated Resident 1's cognition (a mental process of acquiring knowledge and understanding through thought, experience and the senses) was moderately impaired. The MDS indicated Resident 1 was dependent on staff with eating, oral hygiene, toileting hygiene, and personal hygiene. During a review of Resident 1's admission Note dated 1/6/2026 timed 7:06 p.m., the admission Note indicated Resident 1 was admitted from the general acute care hospital (GACH). The nurse practitioner and the physician were made aware of the resident's admission and the resident's medication orders were faxed to the pharmacy. During a review of Resident 1's Order Summary Report, the Order Summary Report indicated the following orders:- Atorvastatin Calcium Oral Tablet 40 milligrams (mg- unit of measurement) give 1 tablet by mouth at bedtime for hyperlipidemia (high cholesterol- when the amount of fat circulating in the bloodstream is high) with start date of 1/6/2026.-Semglee Subcutaneous (under the skin) Solution 100 unit/Milliliter (mL- unit of measurement) Inject 8 units (unit of measurement) subcutaneously (under the skin) at bedtime for diabetes mellitus, with start date of 1/6/2026. During a review of the facility's pharmacy delivery manifest dated 1/7/2026, the delivery manifest indicated that Resident 1's Atorvastatin 40 mg and Semglee wer delivered on 1/7/2026 at 3:22 a.m. During a concurrent interview and record review on 1/2/2026 at 2:35 p.m. with Registered Nurse 2 (RN 2), Resident 1's Medication Administration Record (MAR- a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for the month of January 2026 and progress notes were reviewed. RN 2 stated that the facility receives pharmacy delivery of (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications three times a day, once every shift. RN 2 stated that Resident 1's Atorvastatin was not administered on 1/6/2026 at 9:00 p.m. RN 2 stated that code 8 was documented for Atorvastatin, indicating the medication not available. RN 2 further reviewed Resident 1's MAR for the month of January 2026 and stated that Resident 1's Semglee 8 units was not administered on 1/6/2026 at 9:00 p.m. RN 2 stated that code 8 was documented for Semglee, indicating medication not available. RN 2 stated that because Resident 1 was admitted on [DATE] at 7:06 p.m., Resident 1's medications had not been delivered on time for the scheduled 9:00 p.m. dose and Resident 1 did not receive his medications as prescribed. RN 2 stated that the charge nurse assigned to Resident 1 should have called Resident 1's physician to inform the physician of the missed doses and clarified whether additional orders were needed. RN 2 reviewed Resident 1's progress notes for 1/6/2026 and stated that there was no documented evidence that Resident 1's physician was made aware that Resident 1 did not receive his Atorvastatin and Semglee 9:00 p.m. dose on 1/6/2026. During a concurrent interview and record review on 2/4/2026 at 2:07 p.m. with the Director of Nursing (DON), Resident 1's MAR and physician orders were reviewed. The DON stated that medication orders for newly admitted residents' order are sent to the pharmacy for dispensing, and once the medications are delivered, the licensed nurses administer the first dose of the medication in accordance with the physician's orders. The DON reviewed Resident 1's MAR for January 2026 and stated that the licensed nurse assigned to Resident 1 on admission should have called the physician to clarify the medication orders, including whether the medications could be initiated the following day after delivery, since the resident was admitted on [DATE] at 7:06 p.m. During a review of the facility's policy and procedure (P&P) titled Provider Pharmacy Requirements, last reviewed on 5/27/2025, the P&P indicated it is the policy of the facility that regular and reliable pharmaceutical service is available to provide residents with prescription and non-prescription medications services and related equipment and supplies. The provider pharmacy agrees to perform the following pharmaceutical services including but not limited to: 3) Providing medications package in accordance with the facilities needs and equipment requirements providing routine and timely pharmacy service 7 days per week and emergency pharmacy service 24 hours per day seven days a week. All other new medication or admission orders as ordered by the physician will be available for administration of the next dose. During a review of the facility's P&P titled Charting and Documentation, last reviewed on 5/27/2025, the P&P indicated All services provided to the resident progress toward the care plan goals or any changes in their residence medical physical functional condition shall be documented in the residence medical record. The medical records should facilitate communication between the interdisciplinary team regarding the residence condition and response to care.