STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056337	A. Building B. Wing	05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Panorama Gardens Nursing and Rehabilitation Center	9541 Van Nuys Blvd. Panorama City, CA 91402

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40537 Based on interview and record review, the facility failed to protect the resident's right to be free from physical abuse (deliberately aggressive or violent behavior with the intention to cause harm) for one of four sampled residents (Resident 2) when on 4/23/2025 Resident 1 used his (Resident 1) right hand to graze (a skin injury to the outer layers of the skin) Resident 2's left cheek. This deficient practice resulted in Resident 2 being subjected to physical abuse by Resident 1 while under the care of the facility. Based on the reasonable person concept (used to determine how an average, rational individual would act or respond in a given situation) due to Resident 2's impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses), an individual subjected to physical abuse can have lifetime physical and psychological (mental or emotional) effects including feelings of embarrassment and humiliation (the feeling of being ashamed or losing respect for yourself). Findings: During a review of Resident 1's Admission Record, the Admission Record indicated the facility admitted Resident 1 on 4/17/2025 with diagnoses that included neuropathy (a nerve problem that causes pain, numbness, tingling, swelling, or muscle weakness in different parts of the body), arrhythmia (a problem with the rate or rhythm of your heartbeat), major depressive disorder (a mental health condition characterized by persistent feelings of sadness, hopelessness, and a loss of interest in activities that were once enjoyable), bipolar disorder (a mental health condition that causes extreme mood swings) and encephalopathy (damage or diseases that affects the brain). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 4/21/2025, the MDS indicated Resident 1 had intact cognition. During a review of Resident 1's Change in Condition (COC- when there is a sudden change in a resident's health) Evaluation Form, dated 4/23/2025, timed at 4:31 p.m., the COC indicated that on 4/23/2025 Resident 1 exhibited behavioral symptoms, including physical aggression (refers to acts that cause or threaten physical harm) and verbal aggression (involves the use of words to cause psychological harm such as insults, threats, or name-calling). The COC indicated Resident 1 was observed screaming, yelling and using profane language (refers to language that is considered offensive). The COC indicated that during the incident on 4/23/2025 Resident 1 made physical contact with another Resident (Resident 2), grazing Resident 2's left cheek. (continued on next page)

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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F 0600 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's Physician's Order dated 4/23/2025, timed at 5:34 p.m., the Physician's Order indicated to transfer (Resident 1) to General Acute Care Hospital 1 (GACH 1) for a psychological evaluation (a comprehensive assessment conducted by mental health professionals to understand an individual's mental health status, identify potential issues, and develop appropriate treatment plans) due to aggressive behavior and angry outburst. During a review of Resident 2's Admission Record, the Admission Record indicated the facility originally admitted Resident 2 on 10/21/2024 and readmitted on [DATE] with diagnoses that included dementia (a progressive state of decline in mental abilities) and epilepsy (a chronic [long-term] disease that causes repeated seizures [a sudden, uncontrolled electrical disturbance in the brain that causes temporary changes in muscle tone or movement, behavior, sensation, or awareness]). During a review of Resident 2's History and Physical (H&P- a formal assessment of a resident's health, encompassing both a thorough medical history and a physical examination), dated 3/7/2025, the H&P indicated Resident 2 does not have the capacity to make decisions. During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2 had impaired cognition. During a review of Resident 2's COC Evaluation Form, dated 4/23/24, timed at 5:08 p.m., the COC indicated that on 4/23/2025 Resident 2 was seated outside another resident's room (Resident 1), when Resident 1 began yelling at Resident 2, in response Resident 2 told Resident 1 to shut up. The COC indicated the resident (Resident 2) sustained a skin injury to the left cheek after being grazed by another resident (Resident 1). During an interview on 5/5/2025 at 1:52 p.m., with the Director of Staff Development 1 (DSD 1), DSD 1 stated that she (DSD 1) completed a written statement regarding the incident on 4/23/2025 involving Resident 1 and Resident 2. DSD 1 stated on 4/23/2025, at approximately 3:30 p.m., DSD 1 witnessed an altercation between Resident 1 and Resident 2 in the hallway near Resident 2's room. DSD 1 stated she (DSD 1) stood approximately one (1) foot (ft - unit of length) away from the residents (left side of Resident 1 and right side of Resident 2), with her arms extended between them (Resident 1 and Resident 2) to intervene and separate the residents. DSD 1 stated that on 4/23/2025 Resident 2 was seated outside Resident 1's room when Resident 1 approached Resident 2 and began shouting and behaving aggressively. DSD 1 stated Resident 2 responded by shouting shut up at Resident 1. DSD 1 stated Resident 1 used his (Resident 1) right hand to make physical contact with Resident 2's face, with the intent to cause injury. During a concurrent interview and record review on 5/6/2025 at 3:50 p.m., with the Director of Nursing (DON), the COC form dated 4/23/2025 for Resident 1 and Resident 2 were reviewed. The DON stated the incident between Resident 1 and Resident 2 documented in the COC form is consistent with the definition of abuse (a purposeful contact between one party and another party with the intent to cause harm). The DON stated that the facility must prevent all forms of abuse without exception. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on 5/6/2025 at 3:55 p.m., with the Administrator (ADM), the ADM reviewed DSD 1's written statement dated 5/5/2025 regarding the incident on 4/23/2025 involving Resident 1 and Resident 2 and the Post Event Interdisciplinary Notes dated 4/25/2025 regarding the incident on 4/23/2025 involving Resident 1 and Resident 2. The ADM stated she (ADM) is the facility's abuse coordinator (the person that investigates allegations of abuse in the facility). The ADM stated the abuse incident that occurred on 4/23/2025 cannot be deemed unavoidable and thus must be prevented without exception, which the facility failed to do in this case. During a concurrent interview and record review on 5/6/2025 at 4:07 p.m., with the DON, the DON reviewed the facility's policy and procedure (P&P) titled Abuse: Prevention of and Prohibition Against, with a revised date of 3/2025. The P&P indicated, It is the policy of this facility that each resident has the right to be free from abuse . The DON stated that the facility failed to ensure that Resident 2 was free from abuse when on 4/23/2025, Resident 1 used his (Resident 1) right hand to willfully make contact with the left cheek of Resident 2 with the intent to inflict injury. The DON stated that the facility did not follow the facility's P&P for the prevention of abuse. During a review of the facility's P&P titled Abuse: Prevention of and Prohibition Against, with a revised date of 3/2025. The P&P indicated, It is the policy of this facility that each resident has the right to be free from abuse .