

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056337	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/17/2025
NAME OF PROVIDER OR SUPPLIER Panorama Gardens Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview and record review, the facility failed to ensure the interdisciplinary team (IDT- a group of health care professionals with various areas of expertise who work together toward the goals of the residents' care plan) was involved in determining whether the self-administrations was clinically appropriate for one of four sampled residents (Resident 1) who was not assessed for self-administration for the use of Imodium (used to control and relieve diarrhea) oral tablets and probiotic (a pill containing live good bacteria that can help promote a healthy balance of bacteria in the body) oral tablets that were stored at the resident's bedside. This deficient practice had the potential to result in Resident 1 unsafely administering medications and unsafely access medications stored at bedside. During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 5/24/2025 with diagnoses including right foot fracture (broken bone), age-related cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and senses) decline, and constipation (problem with passing stool). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 5/28/2025, the MDS indicated Resident 1 had the ability to make herself understood and had the ability to understand others. The MDS further indicated that Resident 1 needed setup or clean-up assistance with eating, supervision or touching assistance with oral/personal hygiene, and the resident was dependent on staff sitting to lying in bed and chair transfer. During a review of Resident 1's physician orders, the physician orders indicated the following orders:- Imodium anti-diarrheal (A-D) oral tablet two milligram (mg - a unit of measurement), give one tablet by mouth as needed for diarrhea, family provided medication and at the resident bedside, ordered 5/31/2025.- Probiotic oral tablet, give one tablet by mouth every 12 hours for supplement for 30 days, unsupervised self-administration, ordered 5/31/2025. During a review of Resident 1's MAR for probiotic oral tablet for the periods of 5/31/2025 to 6/30/2025, the MAR indicated the licensed nurses documented U-SA (Unsupervised-Self Administration) in the MAR. During a concurrent interview and record review on 7/17/2025 at 11:47 a.m., with Licensed Vocational Nurse 1 (LVN 1), reviewed Resident 1's physician orders for Imodium and probiotics and Resident 1's MAR for probiotic oral tablet from 5/31/2025 to 6/30/2025. LVN 1 stated that she was able to recall Resident 1 had a hard time with bowel movements and took medications for irritable bowel movements from the beginning of admission. When LVN 1 was asked what U-SA meant, which was documented for the probiotic oral tablet in Resident 1's MAR, LVN 1 stated that the physician order indicated for unsupervised self-administration for probiotics. During a concurrent interview and record review on 7/15/2025 at 1 p.m., with the Director of Nursing (DON), reviewed Resident 1's physician order for Imodium and probiotics and Resident 1's MAR for the periods of 5/31/2025 to 6/30/2025. The DON stated that former Registered Nurse 1 (RN 1), who no longer worked at the facility, marked 'unsupervised' when they input the physician order for Resident 1's probiotics. When the DON was asked about the facility's protocol for resident self-administration of medications, the DON stated that the facility should assess the resident to see if the resident qualifies for self-administration and the result of the assessment should be documented on the medication self-administration form. The DON stated the facility did not assess Resident 1 to see if the resident qualified for self-administration of medications when the physician ordered for bedside Imodium and probiotics on 5/31/2025. The DON stated that she (DON) checked all of Resident 1's medical records but was unable to locate Resident 1's self-administration assessment form. During a review of the facility's policy and procedure (P&P) titled, Nursing Administration, last reviewed 3/10/2025, the P&P indicated, If a resident desires to participate in self-administration, the interdisciplinary team will assess and periodically re-evaluate the resident based on change in the resident's status. The residents cognitive, communication, visual, and physical ability to carry out this responsibility will be evaluated. If the resident is a candidate for self-administration of medications, this will be indicated in the chart. Nursing will be responsible for recording self-administered doses in the resident's medication administration (MAR).</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>Based on interview and record review, the facility failed to develop a comprehensive person-centered care plan (a document designed to facilitate communication among members of the care team that summarizes a resident's health conditions, specific care needs, and current treatments) for one of four sampled residents (Resident 1) addressing Resident 1's self-administration of Imodium (used to control and relieve diarrhea) oral tablets and probiotic (a pill containing live good bacteria that can help promote a healthy balance of bacteria in the body) oral tablets that were stored at the resident's bedside. This deficient practice had the potential to negatively affect the delivery of care and services. During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 5/24/2025 with diagnoses including right foot fracture (broken bone), age-related cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and senses) decline, and constipation (problem with passing stool). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 5/28/2025, the MDS indicated Resident 1 had the ability to make herself understood and had the ability to understand others. The MDS further indicated that Resident 1 needed setup or clean-up assistance with eating, supervision or touching assistance with oral/personal hygiene, and the resident was dependent on staff sitting to lying in bed and chair transfer. During a review of Resident 1's physician orders, the physician orders indicated the following orders:- Imodium anti-diarrheal (A-D) oral tablet two milligram (mg - a unit of measurement), give one tablet by mouth as needed for diarrhea, family provided medication and at the resident bedside, ordered 5/31/2025.- Probiotic oral tablet, give one tablet by mouth every 12 hours for supplement for 30 days, unsupervised self-administration, ordered 5/31/2025. During a concurrent interview and record review on 7/15/2025 at 1:10 p.m., with the Director of Nursing (DON), reviewed Resident 1's physician order for Imodium and probiotics, Resident 1's Medication Administration Record (MAR - a report detailing the medications administered to a resident by a healthcare professional) for the periods of 5/31/2025 to 6/30/2025, and Resident 1's care plans from 5/31/2025 to 7/15/2025. The DON stated that she (DON) checked all of Resident 1's medical records but was unable to locate Resident 1's care plans about self-administration of medications. During a review of the facility's policy and procedure (P&P) titled, Nursing Administration, last reviewed 3/10/2025, the P&P indicated, If a resident desires to participate in self-administration, the interdisciplinary team (IDT- a group of health care professionals with various areas of expertise who work together toward the goals of the residents' care plan) will assess and periodically re-evaluate the resident based on change in the resident's status. The residents cognitive, communication, visual, and physical ability to carry out this responsibility will be evaluated. Appropriate notation of these determinations will be placed in the residents' care plan. During a review of the facility's P&P titled, Comprehensive Person-Centered Care Planning, last reviewed 3/10/2025, the P&P indicated, It is the policy of this facility that the interdisciplinary team shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment.</p>		