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	03/04/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement its policies and procedures (P&P) for ensuring the reporting of a reasonable suspicion of a crime in accordance with Section 1150B of the Act by failing to report an allegation of staff to resident sexual abuse (non-consensual sexual contact of any type with a resident) immediately but no later than two hours to the State Agency (California Department of Public Health [CDPH]), local law enforcement (LLE) agency, or the Ombudsman (an advocate who supports residents by resolving issues related to their health, safety and well-being), for one of eight sampled residents (Resident 2). This deficient practice resulted in the delay for an onsite inspection by the CDPH to ensure the safety of Resident 2 and had the potential to result in unidentified abuse. Findings: During a review of Resident 2's admission Record, the admission Record indicated that the facility originally admitted Resident 2 to the facility on 5/21/2024 and readmitted on [DATE] with diagnoses including fibromyalgia (chronic disorder characterized by widespread muscle and joint pain, fatigue, and cognitive issues), type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and chronic obstructive pulmonary disease (COPD-a progressive, long-term lung disease that makes it hard to breathe by blocking airflow). During a review of Resident 2's Minimum Data Set (MDS- a resident assessment tool) dated 1/19/2026, the MDS indicated that Resident 2 had intact cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) and was dependent on staff with toileting hygiene, shower or bathing, dressing, personal hygiene, and mobility (movement). During a review of Resident 1's admission Record, the admission Record indicated that the facility admitted Resident 1 to the facility on 2/18/2026 with diagnoses including cerebral infarction (a blockage in an artery supplying the brain) due to unspecified occlusion or stenosis (narrowing) of right middle cerebral artery, hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (partial paralysis of the arm, leg, and trunk on the same side of the body) following cerebral infarction affecting left non-dominant side and, type 2 diabetes mellitus. During a review of Resident 1's MDS dated [DATE], the MDS indicated that Resident 1 had intact cognition and was dependent on staff with toileting hygiene, shower or bathing, dressing, personal hygiene, and mobility (movement). During a concurrent interview and record review on 3/3/202 at 12:45 p.m. with the ADM, reviewed Resident 1's nursing progress notes dated 2/28/2026 at 9:15 p.m., which indicated the following: On 2/28/2026 at 7:10 p.m., law enforcement officers arrived at the facility requesting to speak with Resident 1. After interviewing Resident 1, the officers informed RN 4 and Licensed Vocational Nurse 4 (LVN 4) that Resident 1 reported that on 2/26/2026, a male Certified Nursing Assistant (CNA) had entered the room and inappropriately touched Resident 2, who was Resident 1's roommate. The officers interviewed Resident 2, who denied the allegation and did not report any pain, discomfort , or concerns. RN 4 and LVN 4 conducted a head-to-toe skin and body assessment to Resident 2 and did not observe any injuries, bruising, redness to the body, or other abnormal findings on the resident's body. The ADM stated she did not report the allegation to CDPH, LLE, or the Ombudsman because when the officers interviewed (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
	056337	A. Building B. Wing	03/04/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 2, Resident 2 denied the allegation and did not report any injury, or discomfort. The ADM further stated that LVN 4, who had cared for Resident 1 and Resident 2 for the three days following the allegation stated that LVN 4 did not receive any reports or concerns from both residents and from anyone else. The ADM stated that RN 4 called her on 2/28/2026 at approximately 7:15 p.m., and reported Resident 1's allegation of sexual abuse by a staff to Resident 2. The ADM stated that the allegation of sexual abuse should have been reported within 2 hours to CDPH, LLE and the Ombudsman because by failing to report there was a potential for a delay in the implementation of necessary actions to protect residents in the facility. During a review of the facility's policy and procedure (P&P) titled, Abuse: Prevention of and Prohibition last revised on 3/10/2025, indicated that all allegations of abuse, neglect (failure to provide adequate care or services), and misappropriation of resident property (deliberate misplacement, exploitation [taking advantage of a resident], or wrongful, use of resident's belongings or money without the resident's consent), and exploitation (taking advantage of a resident for personal gain through the use of manipulation, intimidation, threats, or coercion) should be reported immediately to the Administrator. Allegations of abuse, neglect, misappropriation of resident property, or exploitation will be reported outside the facility and to the appropriate State or Federal agencies in the applicable timeframes, as per this policy and applicable regulations.