

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/03/2026
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)		
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure one of three sampled residents (Resident 1) received care and services in accordance with professional standards of practice by failing to complete a pain risk assessment following the identification of a new onset of pain on 5/26/2026. This deficient practice had the potential to place Resident 1 at risk for unmanaged pain, resulting in increased discomfort and suffering. During a review of Resident 1's Face Sheet, the Face Sheet indicated the facility originally admitted Resident 1 on 9/25/2021 and readmitted on [DATE] with diagnoses including diabetes (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing) and vascular dementia (a progressive state of decline in mental abilities). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 4/9/2026, the MDS indicated Resident 1's cognitive (the mental process involved in knowing, learning, and understanding things) skills for daily decision making was severely impaired. The MDS further indicated Resident 1 required setup or clean-up assistance from staff with eating, required substantial/maximal assistance with oral hygiene, toileting hygiene, showering or bathing, and partial/moderate assistance with personal hygiene. During a review of Resident 1's Change in Condition (COC- any noticeable or significant alteration in a person's physical health, mental status, or functional ability) Evaluation dated 5/26/2026, timed at 7:30 a.m., the COC indicated the resident (Resident 1) presented with a right ear lower lobe (fleshy, soft, lower section of the outer ear) skin tear (a traumatic wound where the top layer of skin separates from the underlying layers). During a concurrent interview and record review on 6/3/2026, at 12:51 p.m. with Licensed Vocational Nurse 1 (LVN 1), LVN 1 reviewed Resident 1's document titled, Change in Condition [CIC] Follow Up Nurse's Note, dated 5/26/2026 and stated that Resident 1 complained of a new onset of ear pain. During a concurrent interview and record review on 6/3/2026, at 1:04 p.m., with the MDS Nurse (MDSN), the MDSN stated that pain risk assessments are completed upon admission, quarterly (every three months), and as needed when a resident reports a new onset of pain. The MDSN stated that there was no documented evidence that a pain risk assessment had been completed following Resident 1's complaint of new onset ear pain on 5/26/2026. The MDSN further stated that the charge nurse is responsible for completing a pain risk assessment when a new onset of pain is identified. During an interview on 6/3/2026 at 2:03 p.m., with the Director of Nursing (DON), the DON stated that nursing staff are expected to complete a pain risk assessment when a new onset of pain is identified. The DON stated that the pain risk assessment is an important tool used to thoroughly assess and evaluate a resident's pain and assist the facility in developing and implementing an appropriate plan of care to effectively manage Resident 1's pain. During a review of the facility's policy and procedure (P&P) titled, Pain Recognition and Management, reviewed on 3/9/2026, the P&P indicated it is the policy of this facility to ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person centered care plan, and the residents of goals and preferences. The P&P further indicated the facility assists each resident with pain management to maintain or achieve the highest practicable level of well-being and functioning by: interviewing or observing the resident to determine if pain is present; identifying (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 056337	If continuation sheet Page 1 of 3

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	circumstances when pain can be anticipated; evaluating pain and working with the resident to develop a plan of care that considers their needs preferences and goals; developing and implementing a plan, using nonpharmacologic and/or pharmacologic interventions to manage and/or prevent pain. The resident will be evaluated for paying upon admission quarterly and with any changes in their status.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain accurate medical records in accordance with accepted professional standards and practices for one of three sampled residents (Resident 1), by failing to ensure Registered Nurse Supervisor (RNS) documented an assessment conducted during a Change of Condition (COC- any noticeable or significant alteration in a person's physical health, mental status, or functional ability) on 5/26/2026. This deficient practice had the potential to create confusion regarding Resident 1's condition, care and services, and could have placed the resident at risk of receiving inappropriate or incomplete care due to inaccurate medical records documentation. During a review of Resident 1's Face Sheet, the Face Sheet indicated the facility originally admitted Resident 1 on 9/25/2021 and readmitted on [DATE] with diagnoses including diabetes (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing) and vascular dementia (a progressive state of decline in mental abilities). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 4/9/2026, the MDS indicated Resident 1's cognitive (the mental process involved in knowing, learning, and understanding things) skills for daily decision making was severely impaired. The MDS further indicated Resident 1 required setup or clean-up assistance from staff with eating, required substantial/maximal assistance with oral hygiene, toileting hygiene, showering or bathing, and partial/moderate assistance with personal hygiene. During an interview on 6/3/2026 at 11:15 a.m., with RNS, the RNS stated that on 5/26/2026, she (RNS) was notified of an injury to Resident 1's ear. The RNS stated that she assessed Resident 1's right ear and provided first aid (immediate, temporary care given to someone who has been suddenly injured or taken ill). However, RNS stated that she did not document the assessment. The RNS stated that she (RNS) reported the incident to the Director of Nursing (DON). When asked why RNS did not document her assessment of Resident 1's right ear injury, RNS stated that she had other residents to assess and stated that the DON would follow up on the incident. During a concurrent interview and record review on 6/3/2026 at 1:56 p.m., with the DON, the DON reviewed Resident 1's Nursing Progress Notes and Assessments dated 5/26/2026 and stated that there was no documented evidence that RNS documented her assessment of Resident 1's ear injury on 5/26/2026. The DON stated that all registered nurses are expected to document all resident assessments to demonstrate that an assessment was completed by a registered nurse and to ensure accurate clinical records. The DON further stated that it is the responsibility of the registered nurse to verify incidents reported by staff, assess the resident, and document the findings and interventions in the resident's medical record. During a review of the facility policy and procedure (P&P) titled, Documentation and Charting, last reviewed on 5/2026, the P&P indicated it is the policy if this facility to provide: 1. A complete account of the resident's care, treatment, response to the care, signs, symptoms, etc., as well as the progress of the resident's care in an accurate and chronological manner; 4. Nursing service personnel with a record of the physical and mental status of the resident; 6. The elements of quality medical nursing care; 7. A legal record that protects the resident, physician, nurse and the facility. During a review of the facility job description titled, Registered Nurse Supervisor, dated 12/17/2021, the job description indicated to assist in the management and Direction of the nursing department in accordance with current federal, state, and local standards, guidelines, and regulations that govern the facility, and as may be directed by the administrator, the director of nursing and medical director, to ensure that the highest degree of quality care is maintained at all times. The job description further indicates under essential duties and responsibilities reviews nursing personnel medical record documentation to ensure that it is appropriately and accurately descriptive of the nursing care provided; contribute to the development and maintenance of written nursing policies and procedures; provides written and oral reports/recommendations to the director of nursing services and administrator, as necessary/required, concerning the operation of the nursing services department.		