

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

Printed: 10/09/2026
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 07/24/2026
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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, and record review, the facility failed to ensure a resident's call light (a device used by a resident to signal his/her need for assistance from staff) was within reach for one of seven sampled residents (Resident 2). This deficient practice had the potential to delay the provision of services and residents' needs not being met. During a review of Resident 2's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated that the facility originally admitted Resident 2 on 2/26/2024 and re-admitted the resident on 11/1/2024 with diagnoses including dementia (a progressive state of decline in mental abilities), spinal stenosis (a condition where the natural tunnels inside the backbone narrow, which pinches the spinal cord and nerves), and right knee contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion). During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated 6/24/2026, the MDS indicated that Resident 2 was usually able to understand and be understood by others and Resident 2's cognition (ability to think, understand, and make decisions) was severely impaired. The MDS also indicated Resident 2 required maximum (The helper provides more than half the effort) assistance from staff for toileting hygiene, lower body dressing, sitting to lying and lying to sitting in bed, and transferring, and required moderate (The helper does less than half the effort) assistance from staff for oral and personal hygiene and rolling left and right in bed. During a review of Resident 2's Care Plan Report (a document that summarizes a resident's needs, goals, and care/treatment) initiated on 11/4/2024 and updated on 6/23/2026, the care plan indicated Resident 2 had Activities of Daily Living (ADLs- activities such as bathing, dressing and toileting a person performs daily) self-care performance deficit related to included dementia, osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), and impaired range of motion of one side lower extremity (diagnosis with right knee contracture). The care plan indicated an intervention to encourage to call for assistance and keep call light to bed within easy reach and answer as promptly as possible. During a concurrent interview and observation on 7/24/2026 at 8:28 a.m., in Resident 2's room, observed Resident 2 sitting on the edge of the bed near the resident's footboard, and the resident's wheelchair was placed in front of the resident's feet about one foot away. The resident's call light was clipped near the resident's headboard and was not within resident 2's reach. Resident 2 stated that she could not reach the call light and could not press the button. Resident 2 stated she needed assistance to transfer to the wheelchair to go to the activity room. During a concurrent interview and observation on 7/24/2026 at 8:30 a.m., in Resident 2's room, Certified Nursing Assistant 3 (CNA 3) was asked about Resident 2's call light placement after entering Resident 2's room in response to Resident 2's call light. CNA 3 stated that Resident 2's call light was out of the resident's reach. CNA 3 stated the call light should be always placed within the reach of the resident to ensure assistance is provided when the resident needs help. During an interview on 7/24/2026 at 12:56 p.m., with Registered Nurse 1 (RN 1), RN 1 stated that the residents' call lights (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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	should always be in reach to provide timely assistance and meet the residents' needs. During a review of the facility's policy and procedure (P&P), titled Call light last reviewed on 3/9/2026, the P&P indicated, It is the policy of this facility to provide the resident a means of communication with nursing staff. Leave the resident comfortable, ensure the call device is within resident's reach before leaving room. If resident is unable to reach the call light, don't leave the resident unattended.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview and record review, the facility failed to implement 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 seven sampled residents (Resident 1) failing to create a care plan with specific interventions addressing Resident 1's use of a mechanical lift (a medical tool or machine used to safely move people who cannot stand or walk on their own). This deficient practice had the potential to result in unsafe transfers, placing the resident at risk for injury. During a review of Resident 1's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated that the facility originally admitted Resident 1 on 5/21/2024 and re-admitted the resident on 7/1/2026 with diagnoses including fibromyalgia (a long-term medical condition that causes widespread pain, extreme tiredness, and sleep problems), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) with polyneuropathy (damage to many nerves outside the brain and spinal cord, causing numbness, tingling, and muscle weakness), and morbid (severe) obesity (a chronic medical disease characterized by having too much body fat). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 7/10/2026, the MDS indicated that Resident 1 was able to understand and be understood by others, and Resident 1's cognition (ability to think, understand, and make decisions) was intact. The MDS also indicated Resident 1 was dependent (the resident does not perform the activity at all and requires full assistance from one helper or the combined effort of two or more helpers) on staff for toileting hygiene, showering, lower body dressing and transferring, and required maximum (helper does more than half the effort) assistance from staff for upper body dressing, personal hygiene, and rolling left and right in bed. During a review of Resident 1's weights and vitals summary dated 7/1/2026, the weigh summary indicated the following resident's body weights: On 7/2/2026, the body weight was 254 pounds (lbs. - a unit of weight measurement). On 7/9/2026, the body weight was 255 lbs. On 7/16/2026, the body weight was 256 lbs. During a review of Resident 1's Care Plan Report (a document that summarizes a resident's needs, goals, and care/treatment) initiated on 7/1/2026 and updated on 7/8/2026, the care plan indicated Resident 1 had Activities of Daily Living (ADLs- activities such as bathing, dressing and toileting a person performs daily) self-care performance deficit related to included fibromyalgia, DM, impaired range of motion on both upper extremities, and use of a mechanical lift. The care plan did not indicate specific instructions on the use of a mechanical lift. During an interview on 7/24/2026 at 12:38 p.m., with Registered Nurse 1 (RN 1), RN 1 reviewed Resident 1's Care Plan Report and Resident 1's weight summary and stated that the resident's body weight was stable and currently weighing at 256 lbs. RN 1 stated that the mechanical lift sling (a strong fabric seat or hammock used with a machine hoist to safely move people who cannot walk or stand on their own) size would be based on the resident's body weight. RN 1 reviewed Resident 1's care plans for ADL assists and stated that the care plan did not indicate the resident's current weight and the corresponding sling size for use with the mechanical lift. RN 1 stated Resident 1's care plan lacked the specific interventions for the use of a mechanical lift and was not comprehensive and was not person-centered. During a review of the facility's policy and procedure (P&P), titled Comprehensive Person-Centered Care Planning last reviewed on 3/9/2026, the P&P indicated, It is the policy of this facility that the interdisciplinary team (IDT - a group of health (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care professionals with various areas of expertise who work together toward the goals of the residents' care plan) 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. The resident's comprehensive plan of care will be reviewed and/or revised by the IDT after each assessment, including both the comprehensive and quarterly review assessments. During a review of the facility's P&P, titled Quality of Care last reviewed on 3/9/2026, the P&P for the mechanical lift transfers indicated, Mechanical lift transfers are usually used for residents who are very large or extremely dependent. It is very important to use the appropriate sling with the appropriate lift and to use the correct size sling that is specified for each individual. Always use the appropriate size sling to ensure safety,		