

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: 056351	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/14/2026
NAME OF PROVIDER OR SUPPLIER Chatsworth Park Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 10610 Owensmouth Chatsworth, CA 91311	
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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain resident room temperatures within the required range of 71 degrees Fahrenheit (F - a scale of temperature) to 81 F for one of five sampled residents (Resident 1) room. This deficient practice violated the resident's right to a comfortable, homelike environment and had the potential to adversely affect the resident's quality of life. 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 3/22/2026 and re-admitted the resident on 4/20/2026 with diagnoses including congestive heart failure (CHF- a heart disorder which causes the heart to not pump blood efficiently), anemia (a condition in which the body does not have enough healthy red blood cells), diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing), and anxiety (a mental condition, involving persistent, excessive, and uncontrollable fear or dread about daily situations). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 4/24/2026, the MDS indicated that Resident 1 had adequate hearing and vision, clear speech, was able to understand and be understood by others, and was cognitively intact (normal thinking and memory with no significant impairment). The MDS also indicated that Resident 1 had impaired range of motion (the measurement of the distance and direction a joint can move) in one lower limb (hip, knee, ankle, or foot) and required maximum assistance from staff for toileting hygiene and bed mobility (movement), including sitting to lying and lying to sitting on the side of the bed. During a concurrent observation and interview on 7/13/2026 at 2:51 p.m., in Resident 1's room with Maintenance Assistant 1 (MA 1), observed MA 1 measured the room temperature using an infrared thermometer (a handheld device that measures the surface temperature of an object from a distance). The temperature was measured from Resident 1's roommate's footboard (Bed C) toward Resident 1's (Bed D) wall, and MA 1 stated the temperature reading was 82.4 F. During an interview on 7/13/2026 at 3:30 p.m., Resident 1 stated that the room had felt hot in the afternoon a few days prior, and that Resident 1 had asked a nurse to increase the air conditioning (refers to the cooling system). Resident 1 stated that the nurse informed Resident 1 that the other roommates did not want the temperature changed and did not adjust the temperature. Resident 1 further stated that, on that day, it felt like roasting in the my own skin. During an observation and interview on 7/13/2026 at 3:49 p.m., in the hallway outside Resident 1's room with Maintenance Consultant 1 (MC 1), MC 1 stated that the acceptable room temperature range was 71 F to 81 F and that the reading of 82.4 F in Resident 1's room was too hot. Upon checking the vents in the hallway outside Resident 1's room, MC 1 stated that three vents were not blowing air, including the vent between rooms [ROOM NUMBERS], the vent outside the MDS office, and the vent outside room [ROOM NUMBER]. During an interview on (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: 056351
		If continuation sheet Page 1 of 6

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7/13/2026 at 4:30 p.m. with MC 1, MC 1 stated that something had gone wrong with the Heating, Ventilation, and Air Conditioning (HVAC - a system that controls the indoor climate by managing temperature, humidity, air movement, and air quality) unit that serviced the hallway where Resident 1's room was located. MC 1 stated that all of the vents should have been blowing cold air. During an interview on 7/14/2026 at 7:24 a.m., with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated that they did not know which key opened the thermostat lock boxes (a physical, secure, clear plastic or metal cover placed over a wall thermostat to prevent unauthorized temperature adjustments) when asked how room temperatures were regulated at night if a resident complained. LVN 2 further stated they would notify the morning nursing staff to contact maintenance personnel and would not adjust the thermostat lock boxes. LVN 2 stated in the meantime, staff would offer an electric fan or extra blankets. When LVN 2 was asked what would happen if a resident did not want an electric fan and continued to complain of being hot, LVN 2 stated they would wait until morning and endorse the issue to the next shift to contact the maintenance department. During an interview on 7/14/2026 at 7:53 a.m., with Registered Nurse 1 (RN 1), RN 1 stated that no keys were available to open the thermostat lock boxes to adjust room temperatures. RN 1 stated that the key had been unavailable for a couple of years and that the facility did not allow staff to access the thermostat lock boxes during the nighttime. RN 1 further stated that if residents complained that their rooms were too hot at night, staff would offer electric fans, and wait until maintenance personnel who had the key arrived at 7 a.m. the following morning to adjust the thermostat lock boxes. RN 1 stated that staff could not adjust room temperatures regulated by the central air conditioning system during the night. During an interview on 7/14/2026 at 8:15 a.m., with MC 1, MC 1 stated that an HVAC technician discovered on 7/13/2026 that the vents serving Resident 1's hallway had become disconnected from the HVAC unit. During an interview on 7/14/2026 at 9:18 a.m., with MA 1, MA 1 stated that the nursing staff had the key to open the thermostat lock boxes and that nursing staff should adjust residents' room temperatures, if needed, to provide a comfortable environment when maintenance personnel were not available in the building. During a review of the Service Call invoice (a detailed, itemized document sent by a provider of goods or services to a customer) dated 7/14/2026, the invoice indicated, Technician diagnosed the cause of the lack of airflow to the hallways and found a section of ductwork (a network of tubes used in HVAC systems) had become disconnected due to age and deterioration. During a review of the facility's policy and procedures (P&P) titled, Maintenance Policy, last reviewed on 1/2026, the P&P indicated that the building, equipment, and overall environment were to remain safe, clean, and functional for residents, staff, and visitors.		

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. Based on observation, interview, and record review, the facility failed to develop and implement policies and procedures (P&P) for monitoring air temperatures and Heating, Ventilation, and Air Conditioning (HVAC - controls indoor climate by managing temperature, humidity, air movement, and air purity) units by failing to establish written procedures that directed how room temperatures were to be measured, documented, and monitored and how HVAC units were to be inspected, monitored and documented. This failure had the potential to result in maintenance personnel monitoring air temperatures and HVAC systems in an inconsistent and inaccurate manner, potentially affecting the facility's ability to maintain a safe and comfortable environment for residents. During a record review of the facility's Weekly Air Temperature Record, the Weekly Air Temperature Record indicated the following: On 6/26/2026, the outside temperature was 83 degrees Fahrenheit (F - a scale of temperature), Station 1 was 73 F, Station 2 was 73 F, Station 3 was 74 F, Station 4 was 75 F, the Lobby was 73 F, and the Offices were 73 F. On 7/3/2026, the outside temperature was 81 F, Station 1 was 75 F, Station 2 was 74 F, Station 3 was 74 F, Station 4 was 74 F, the Lobby was 74 F, and the Offices were 74 F. On 7/10/2026, the outside temperature was 96 F, Station 1 was 75 F, Station 2 was 74 F, Station 3 was 74 F, Station 4 was 74 F, the Lobby was 73 F, and the Offices were 74 F. During a review of the facility's Change of Air Filters on Air Conditioner Units (Check and Change Once a Month) log, the Change of Air Filters on Air Conditioner Units log indicated that entries dated 5/26/2026, 6/26/2026 and 7/26/2026 each consisted of a single downward arrow mark extending from Unit 1 through Unit 16. During an interview on 7/13/2026 at 3:49 p.m., with Maintenance Consultant 1 (MC 1), MC 1 stated the facility had 17 central air conditioning units, room temperatures were checked daily, and temperatures should be taken at knee level. During a follow-up interview on 7/14/2026 at 8:15 a.m., with MC 1, MC 1 stated that the facility's process for weekly temperature monitoring was to randomly check several resident rooms at each station and document the average temperature for each station. MC 1 stated that the Weekly Air Temperature Log was correct, as the facility had been following that process. During a concurrent interview and record review on 7/14/2026 at 11:22 a.m., with MC 1, MC 1 reviewed the Change of Air Filters on Air Conditioner Units log dated 5/26/2026, 6/26/2026 and 7/26/2026. MC 1 stated that the most recent documented air filter change was 7/26/2026. MC 1 stated that the log did not identify what HVAC system components were checked beyond air filter replacement and did not identify the individual who performed the inspection or maintenance. MC 1 stated that each HVAC unit received a monthly inspection, air filters were replaced, and the coils were cleaned. MC 1 further stated that the facility did not have written P&P addressing room temperature monitoring. During a concurrent interview and record review on 7/14/2026 at 11:27 a.m., with the Administrator (ADM), the ADM reviewed the Change of Air Filters on Air Conditioner Units log dated 5/26/2026, 6/26/2026 and 7/26/2026. The ADM stated that the downward arrows extending through Units 1 through 16 indicated that all HVAC units had been checked and the air filters replaced. The ADM stated that the facility's current process for weekly room temperature monitoring involved MA 1 obtaining temperatures in all resident rooms, documenting the readings on paper, and providing the documentation to the ADM. The ADM stated that the ADM then calculated and documented the average temperature for each nursing station. The ADM further stated that the facility did not have written P&P for room temperature monitoring or HVAC inspections that specified the inspection process, required inspection components, documentation (continued on next page)		

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	requirements, or staff responsibilities. During a review of the facility's P&P, titled Governing Body (a group of people that has the authority to exercise governance over an organization), last reviewed on 1/2026, the P&P indicated that the Governing Body was responsible for establishing and implementing policies regarding the management and operation of the facility. The P&P also indicated that this facility's Governing Body includes the Administrator, Market Leader, Clinical Market Leader, and the Director of Nursing Services. During a review of the facility's job description, titled Executive Director/Administrator, last reviewed on 10/2021, the job description indicated that one of the Administrator's responsibilities was to develop and implement facility policies and procedures.		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain the Heating, Ventilation, and Air Conditioning (HVAC - a system that controls indoor climate by managing temperature, humidity, air movement, and air quality) unit in functioning condition to provide a comfortable environment for one of five sampled residents (Resident 1). This failure resulted in Resident 1 expressing that it felt like roasting in my own skin and had the potential to create an uncomfortably hot environment for the residents, staff, and visitors. 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 3/22/2026 and re-admitted the resident on 4/20/2026 with diagnoses including congestive heart failure (CHF- a heart disorder which causes the heart to not pump blood efficiently), anemia (a condition in which the body does not have enough healthy red blood cells), diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing), and anxiety (a mental condition, involving persistent, excessive, and uncontrollable fear or dread about daily situations). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 4/24/2026, the MDS indicated that Resident 1 had adequate hearing and vision, clear speech, was able to understand and be understood by others, and was cognitively intact (normal thinking and memory with no significant impairment). The MDS also indicated that Resident 1 had impaired range of motion (the measurement of the distance and direction a joint can move) in one lower limb (hip, knee, ankle, or foot) and required maximum assistance from staff for toileting hygiene and bed mobility (movement), including sitting to lying and lying to sitting on the side of the bed. During a concurrent observation and interview on 7/13/2026 at 2:51 p.m., in Resident 1's room with Maintenance Assistant 1 (MA 1), observed MA 1 measured the room temperature using an infrared thermometer (a handheld device that measures the surface temperature of an object from a distance). The temperature was measured from Resident 1's roommate's footboard (Bed C) toward Resident 1's (Bed D) wall, and MA 1 stated the temperature reading was 82.4 degrees Fahrenheit (F - a scale of temperature). During an interview on 7/13/2026 at 3:30 p.m., Resident 1 stated that the room had felt hot in the afternoon a few days prior, and that Resident 1 had asked a nurse to increase the air conditioning (refers to the cooling system). Resident 1 stated that the nurse informed Resident 1 that the other roommates did not want the temperature changed and did not adjust the temperature. Resident 1 further stated that, on that day, it felt like roasting in the my own skin. During an observation and interview on 7/13/2026 at 3:49 p.m., in the hallway outside Resident 1's room with Maintenance Consultant 1 (MC 1), MC 1 stated that the acceptable room temperature range was 71 F to 81 F and that the reading of 82.4 F in Resident 1's room was too hot. Upon checking the vents in the hallway outside Resident 1's room, MC 1 stated that three vents were not blowing air, including the vent between rooms [ROOM NUMBERS], the vent outside the MDS office, and the vent outside room [ROOM NUMBER]. During an interview on 7/13/2026 at 4:30 p.m. with MC 1, MC 1 stated that something had gone wrong with the HVAC unit that serviced the hallway where Resident 1's room was located. MC 1 stated that all of the vents should have been blowing cold air. During an interview on 7/14/2026 at 8:15 a.m., with MC 1, MC 1 stated that an HVAC technician discovered on 7/13/2026 that the vents serving Resident 1's hallway had become disconnected from the HVAC unit. During a review of the Service Call invoice (a detailed, itemized document sent by a provider of goods or services to a customer) dated 7/14/2026, the invoice indicated, Technician diagnosed the cause of (continued on next page)		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the lack of airflow to the hallways and found a section of ductwork (a network of tubes used in HVAC systems) had become disconnected due to age and deterioration. During a review of the facility's policy and procedures (P&P) titled Homelike Environment, last reviewed on 1/2026, the P&P indicated that the facility environment will be designed and maintained to promote comfort, with the purpose of providing a safe, welcoming and comfortable living environment for residents.		