

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555380	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/04/2025
NAME OF PROVIDER OR SUPPLIER Encino Hospital Medical Center D/P Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 16237 Ventura Blvd Encino, CA 91436	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and food preparation practices in the kitchen when: a. A plastic scoop was left in a food bin, in the dry storage area, during the initial kitchen tour. b. The facility failed to ensure food was labeled with a date, stored correctly and disposed of upon expiration. ^ These failures had the potential to result in harmful bacteria growth and cross contamination (a transfer of harmful bacteria from one place to another or one object to another) that could lead to foodborne illness (illness caused by food contaminated with bacteria, viruses, and other toxins) in three of three medically compromised residents who received food from the kitchen. Findings: a. During an initial kitchen tour observation on 12/1/2025 at 9:16 am in the dry storage area, a plastic scoop was left in a large bin labeled flour. The bin contained white powdery material, and the scoop was covered in that white powdery material. During a concurrent observation and interview on 12/1/2025 at 9:19 am with the Director of Food and Nutrition (DFN), the DFN looked at the food bin with the white powdery material and stated scoops should never be left in any dry good bin. The DFN stated this particular bin was flour and once her staff uses any dry good, the scoop must be removed and stored separately to prevent the growth of bacteria and cross contamination. During a review of the facility's policy and procedures (P&P), titled, Food Storage, last reviewed on 2/17/2025, the P&P indicated the purpose is to ensure safe storage of food in order to prevent occurrence of foodborne illness. The P&P further indicated that scoops are never to be stored inside containers in the dry storage area. b. During a concurrent observation and interview on 12/1/2025 at 9:20 am with the Dietary Aid (DA), in the facility kitchen, ten bags of frozen vegetables were observed to be opened and did not have a label with the open date and expiration date. The DA stated that all food items are to be labeled with the date they were opened and a new expiration date. The DA stated that without an open date label on the food items, the staff would have no way of knowing when they were opened, and therefore the items should not be given to the residents because their (food) safety and freshness could not be verified. The DA stated residents can get sick from eating expired food. ^ During an interview on 12/1/2025 at 9:30 am with the Director of Food and Nutrition (DFN), the DFN stated all food items should be labeled with an open date and expiration date that is one month after the date of opening. ^^ ^ (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) titled, Food Labeling and Dating, dated 2/17/2025, the P&P indicated, the purpose of food labeling and dating is To ensure that food is labeled and dated in accordance with accepted food safety standards to prevent foodborne illness. The P&P also indicated, All stored foods shall be labeled to indicated type of product and date prepared or date the product is to be discarded.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview, and record review the facility failed to ensure residents who were incontinent (lacks voluntary control over urination) of bladder (organ in the pelvis that stores urine) received appropriate treatment and services to prevent urinary tract infections (UTI, common infections that happen when bacteria infect the urinary tract) by failing to ensure the urinary catheter (a thin flexible tube that is inserted into the bladder to help drain urine) collection bag tubing was not looped or coiled to allow the urine to flow freely into the collection bag for two of two residents (Resident 1 and Resident 12) reviewed under the urinary catheter care area. This failure had the potential to result in the backflow of urine into the residents' bladders, which can cause urinary tract infections (UTI- an infection in the bladder/urinary tract). Findings: a. During a review of Resident 12's admission Record, the admission Record indicated, the facility initially admitted Resident 12 to the facility on 6/1/2008 and readmitted the resident on 9/30/2025. The admission Record indicated Resident 12 has a history of respiratory failure (a life-threatening condition where the lungs cannot effectively exchange gases; often requiring oxygen or mechanical ventilation), seizure (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness) disorder, dysphagia (difficulty swallowing), urethral stricture (a narrowing of the urethra, the tube that carries urine out of the body, caused by scar tissue), obesity, immobility with chronic (long term) contractures (a stiffening/shortening at any joint, that reduces the joint's range of motion) with hypercoagulable state (increased risk for developing blood clots). During a review of Resident 12's Minimum Data Set (MDS - a resident assessment tool), dated 11/14/2025, the MDS indicated Resident 12 was in a persistent vegetative state (is a condition where a person is alive or awake but not aware of themselves or their surroundings) with no discernible consciousness. The MDS indicated Resident 12 was utilizing an indwelling urinary catheter appliance. During a review of Resident 12's Plan of Care, dated 11/14/2025, the Plan of Care indicated Resident 12 has a potential for infection related to the presence of indwelling foley (a type of urinary catheter) catheter due to urinary retention. The goal was to prevent signs and symptoms of UTI. The interventions included to check and ensure the indwelling catheter tubing is not kinked and there is free flow of urine at all times. During a review of Resident 12's Physician Orders, the Physician Orders indicated an order dated 9/30/2025 for an indwelling urinary catheter #18 x 10 milliliter (ml- a unit of measurement for fluid volume) due to dependent drainage. During a concurrent observation and interview on 12/1/2025 at 10:17 am with Certified Nurse Assistant 1 (CNA 1), in Resident 12's room, Resident 12's urinary catheter tubing was looped preventing the free flow of urine through the tubing and into the collection bag. CNA 1 stated the urinary tubing should not be looped and proceeded to move Resident 12's collection bag further towards the foot of Resident 12's bed to allow the tubing to uncoil and for urine to flow freely into the collection bag. CNA 1 stated the backup of urine in the tubing can cause Resident 12 to have a UTI. During an interview on 12/1/2025 at 10:45 am with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated indwelling urinary catheter tubing should not be coiled or looped to allow for the free flow of urine to prevent UTI's from occurring. During an interview on 12/3/2025 at 8:45 am with the Nurse Manager (NM), the NM stated that it is important to ensure the indwelling urinary catheter tubing is not coiled or looped to allow for the free flow of urine into the collection bag. The NM stated, if the urine is not draining into the collection bag, it could back up into the resident's bladder and cause a UTI. b. During a review of Resident 1's admission Record, the admission Record indicated the facility initially admitted Resident 1 to the facility on 7/19/2018 and readmitted the resident on 1/1/2025. Resident 1 has a past medical history including chronic encephalopathy (a disease in which the functioning of the brain is affected by some agent or condition), motor vehicle accident with traumatic brain injury (TBI-a disruption in the normal function of the brain that can be caused by a bump, blow, or jolt to the head), and tracheostomy (a surgical (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	procedure to create an opening (stoma) in the neck directly into the trachea (windpipe). During a review of Resident 1's MDS, the MDS indicated Resident 1 was in a persistent vegetative state with no discernible consciousness. The MDS indicated Resident 1 was utilizing an indwelling urinary catheter appliance. During a review of Resident 1's Plan of Care dated 1/1/2025, the Plan of Care indicated Resident 1 has a potential for infection related to the presence of indwelling foley catheter due to urinary retention. The goal was to prevent signs and symptoms of UTI. The interventions included to check and ensure the indwelling catheter tubing is not kinked and there is free flow of urine at all times. During a review of Resident 1's Physician Orders, the Physician Orders indicated an order dated 12/02/2019 for an indwelling urinary Foley (type of urinary catheter that is inserted through the urethra and held in place by a balloon) catheter #20 x 10 ml placed for urinary retention as needed when plugged or dislodged. During a concurrent observation and interview on 12/1/2025 at 11:20 am with Certified Nurse Assistant 2 (CNA 2), in Resident 1's room, Resident 1's urinary catheter tubing was looped preventing the free flow of urine through the tubing and into the collection bag. CNA 2 stated the urinary catheter's tubing should be free of loops or kinks and proceeded to uncoil the tubing causing the urine to flow freely into the collection bag. CNA 2 stated back up of urine in the tubing can cause Resident 1 to have an infection. During an interview on 12/1/2025 at 10:45 am with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated indwelling urinary catheter tubing should not be coiled or looped to allow for the free flow of urine to prevent UTI's from occurring. During an interview on 12/3/2025 at 8:45 AM with the Nurse Manager (NM), the NM stated that it is important to ensure the indwelling urinary catheter tubing is not coiled or looped to allow for the free flow of urine into the collection bag. The NM stated that if the urine is not draining into the collection bag, it could back up into the resident's bladder and cause a UTI. During a review of the facility's policy and procedure (P&P) titled, Prevention of Catheter-Associated Urinary Tract Infections (CAUTI), dated 3/2024, indicated, the purpose of the policy is To improve patient safety and outcomes by preventing catheter-associated urinary tract infections. The P&P also indicated, to Maintain unobstructed urine flow . Maintain the catheter and collecting tube free from kinking.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide appropriate treatment and services to prevent complications of enteral feeding (EF - a form of nutrition that is delivered through a tube in the stomach) by failing to indicate with a label, the date and time the enteral feeding tubing was started for one of one sampled resident (Resident 18) investigated under the tube feeding care area. This deficient practice had the potential for administering expired enteral feeding which could place Resident 18 at risk for complications such as diarrhea (loose, watery stool) or vomiting leading to dehydration (loss or removal of water). Findings: During a review of Resident 18's Admission/Registration Record printed on [DATE], the Admission/Registration Record indicated the facility admitted Resident 18 on [DATE]. During a review of Resident 18's History and Physical (H&P) dated [DATE], the H&P indicated Resident 18's diagnoses included hypoxic brain injury (damage to the brain from not getting enough oxygen), ventilator (a machine that breathes for you or helps you breathe) dependent respiratory failure (a serious condition that makes it difficult to breathe on your own), and gastrostomy (G-tube, a surgical opening fitted with a device to allow feedings to be administered directly to the stomach). During a review of Resident 18's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated [DATE], the MDS indicated Resident 18 was ventilator dependent and did not have the ability to make himself understood and understand others. The MDS indicated Resident 18 was completely dependent on facility staff for all of his needs. During a review of Resident 18's Physician Orders, the Physician Order indicated an order dated [DATE] for Jevity 1.2 (a brand name of EF) 80ml/hr (milliliters/hour - measurement of volume) x 16 hours via G-tube. During an observation on [DATE] at 8:18 am in Resident 18's room, Resident 18 was lying in bed. Observed an EF hanging on a pump and connected to Resident 18's G-tube. The tubing that was attached the EF to the G-tube did not have a label to indicate what date and time it was hung. During a concurrent observation and interview on [DATE] at 8:21 am in Resident 18's room with Licensed Vocational Nurse (LVN 2), LVN 2 looked at the EF tubing and stated the prior nurse either forgot to put a label on or the label fell off. LVN 2 stated the tubing must be labeled so other staff would know when the EF was started and that the tubing and EF must be discarded and changed every day to prevent spoilage and stomach issues. During an interview on [DATE] at 10:42 am in with Registered Nurse (RN 1), RN 1 stated all tubing, and EF are changed daily and the appropriate practice is to label each EF and tubing with the date and time it was started to prevent gastrointestinal (relating to the stomach and intestines) issues and possibly infection. During a review of the facility's Policy and Procedure, (P&P) titled Enteral Feeding via G or J tube, Continuous (Pump) last reviewed 2/2025, the P&P indicated formula may hang for 24 hours and the bag (feed) and tubing must be labeled with the date and time it was hung.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on interview and record review, the facility failed to ensure the facility's kitchen ice machine Daily Scoop Sanitizer log was completed daily to indicate the ice scooper was sanitized daily. This failure had the potential to result in cross contamination (the process by which bacteria or other microorganisms are unintentionally transferred from one substance or object to another) of harmful bacteria that could contaminate the ice and cause foodborne illness (an illness caused by food contaminated with bacteria, viruses, and other toxins) in three of three medically compromised and vulnerable residents who received food from the kitchen. Findings: During a concurrent interview and record review on 12/3/2025 at 11:00 AM with the Director of Food and Nutrition (DFN), the facility kitchen ice machine Daily Scoop Sanitizer Log, dated 12/2025, was reviewed. The log indicated, the sanitization of the ice machine scoop was not documented on 12/2/2025 and on 9/7/2025. The DFN stated the log is to be completed daily at the end of the day by the night shift. The DFN stated the night shift sanitizes the scoop by first washing it, then placing it into the sanitizer. The DFN also stated without the log documentation, there is no other way of knowing if the ice scoop was sanitized. The DFN stated if the ice scoop was not sanitized, it could be dirty, which could lead to a food safety and sanitization issue for the residents. During a review of the facility's policy and procedure (P&P) titled, Dispensing of Ice, dated 2/17/2025, the P&P indicated, the purpose of this policy is To dispense ice without contamination. The P&P also indicated, Sanitation of ice dispensing equipment will be maintained per established cleaning schedule . Scoop and container will be sanitized daily.		