STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555519	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Care Center on Hazeltine, LLC	6835 Hazeltine Ave. Van Nuys, CA 91405

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to: 1. Reconcile (the process of comparing transactions and activity to supporting documentation) two (2) medication emergency kits ([eKIT] - storage container for emergency use medications) containing Controlled Substances ([CS]- medications which have a potential for abuse and may also lead to physical or psychological dependence, also known as Controlled Medications) for 12/2025, in one (1) of one (1) inspected Medication Rooms (Medication room [ROOM NUMBER].) 2. Reconcile one (1) medication eKIT containing CSs for 12/2025, in one (1) of two (2) inspected Medication Carts (Medication Cart 1.) As a result, control and accountability of CSs and availability of medications did not follow state and federal regulations and facility policy and procedures. These deficient practices increased the opportunity for CS diversion (the transfer of a controlled medication or other medication from a lawful to an unlawful channel of distribution or use,) and the risk that residents in the facility could have accidental exposure to harmful medications and delayed medication treatment during emergencies possibly leading to physical and psychosocial harm, and hospitalizationFindings: During an observation on 12/16/2025 at 10:18 a.m., with Licensed Vocational Nurse (LVN) 3, in Medication Cart 1, there was: 1. One (1) medication eKIT containing CSs stored at room temperature and labeled 16, without an accountability log for the reconciliation of CS inventory count at every shift change for 12/2025. During a concurrent interview, LVN 3 stated that all CSs, including medication eKITs containing CSs should be reconciled and counted at every shift. LVN 3 stated the eKIT labeled 16 containing CSs in Medication Cart 1 was not reconciled with a count at every shift in 12/2025, and it was important to account for all CSs to ensure accountability and prevent CS diversion. During an observation on 12/15/2025 at 12:40 p.m., with LVN 2, in Medication room [ROOM NUMBER], there was: 1. One (1) medication eKIT containing CSs stored in the refrigerator and labeled 24, without an accountability log for the reconciliation of CS inventory count at every shift change for 12/2025. 2. One (1) medication eKIT containing CSs stored at room temperature and labeled 8, without an accountability log for the reconciliation of CS inventory count at every shift change for 12/2025. During a concurrent interview, LVN 2 stated that all CSs, including medication eKITs containing CSs, should be reconciled at every shift. LVN 2 stated the eKIT labeled 24 in the refrigerator and the eKIT labeled 8 at room temperature containing CSs in Medication room [ROOM NUMBER] was not reconciled for inventory count at every shift in 12/2025, and it was important to account for all CSs to ensure accountability and prevent CS diversion. During an interview on 12/16/2025 at 3 p.m., with the Assistant Director of Nursing (ADON,) the ADON stated medication eKITs containing CSs needed to be counted and reconciled at every shift change to ensure accountability and prevent CS diversion. The DON stated eKIT labeled 16 in Medication Cart 1, the eKIT labeled 24 in the refrigerator in Medication room [ROOM NUMBER] and the eKIT labeled 8 at room temperature in Medication room [ROOM NUMBER], all contained CSs and were not reconciled at every shift in 12/2025. During a review of the facility's Policy and Procedures (P&P,) titled Safeguarding Controlled Substances, last reviewed 1/28/2025, the P&P indicated: The facility has established guidelines for safe handling receiving, (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	storing, administering, reconciling, and safeguarding controlled substances. Purpose: To minimize the time between identification and actual loss or diversion of medications or suspected controlled substance diversion involving any employee, determination of the extent of loss or diversion and to safeguard patients and their property. Definitions: Controlled Medications are substances that have an accepted medical use (medications which fall under US Drug Enforcement Agency (DEA) Schedules II-V), have a potential for abuse, ranging from low to high, and may also lead to physical or psychological dependence. 13. Controlled substances will be counted at the onset and completion of each shift by two nurses and verified accurately through each nurses' signature on the reconciliation log. Controlled Drug Count/Change of Shift Reconciliation 1. Each individual controlled substance must be counted when there is a change in shift nurse.2. The on-coming licensed nurse will view and verify each medication supply and amount[s] remaining, while the off-going nurse calls out the resident name, medication, and amounts remaining on controlled logs.3. The count should be completed in a diligent manner and the oncoming nurse should examine tablets and medications carefully during the count.4. Narcotic e-kits should be checked & verified as present/sealed or reconciled as indicated.5. Both on-coming, and off-going licensed nurses will sign the controlled drug count verification form when deemed accurate. Following this procedure and confirmation of controlled substance accuracy, the on-coming nurse may take accountability of the medication cart and keys. During a review of the facility's P&P, titled Emergency Pharmacy Services and Emergency kits, last reviewed 1/28/2025, the P&P indicated: Accountability for controlled substances stored in the emergency kit is maintained as follows:c. The incoming and outgoing nurses verify the inventory of controlled substances at each change of shift or exchange of keys.

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(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 proper food handling practices by failing to: 1. Ensure bins containing potatoes and onions were labeled with a date of when they were received. 2. Ensure one sweet and sour sauce container was clean with no residue left outside of the container. 3. Ensure the ice machine water filter was changed according to its replace date and according to the manufacturer's policy. 4. Ensure the residents' refrigerator temperature log was updated daily for three dates. 5. Ensure chocolate milk and vanilla and chocolate ice cream inside the residents' refrigerator were labeled with name and date. These deficient practices had the potential to result in harmful bacteria growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to food borne illness (a disease caused by consuming food or drinks that are contaminated by germs or chemicals) in 44 of 46 medically compromised residents who received food and ice from the kitchen. Findings: 1. During a concurrent kitchen observation and interview on 12/15/2025 at 7:53 a.m., with [NAME] 1 (CK 1), observed one bin with potatoes and one bin with onions not labeled with the date it was received. CK 1 verified and stated that all perishable (usually food, that is likely to spoil, decay or go bad) food should be labeled with the date when it was received to be able to know what to use first when serving food. During an interview on 12/15/2025 at 3:25 p.m., with the Dietary Supervisor (DS), the DS stated that all perishable food delivered to the facility should be labeled with the date when it was received due to food safety. During a review a review of facility's policy and procedure (P&P) titled, Food Receiving and Storage, revised on 1/2025, the P&P indicated, When food, food products or beverages are delivered to the nursing home, facility staff must inspect these items for safe transport and quality upon receipt and ensure their proper storage, keeping track of when to discard perishable foods and covering, labeling, and dating all foods stored. 2. During a concurrent observation and interview on 12/15/2025 at 8:14 a.m., with CK 1, observed one sweet and sour sauce container with residue left outside of the container. CK 1 verified and stated that the sweet and sour sauce container was dirty, and it should be clean with no residue left prior to returning it back to the refrigerator. During an interview on 12/15/2025 at 3:25 p.m., with the DS, the DS stated that they need to clean the sauce containers after each use due to possible risk of contamination and food safety. During a review a review of facility's P&P titled, Safe Food Preparation, revised on 1/2025, the P&P indicated, Facility follows proper sanitation and food handling practices to prevent the outbreak of foodborne illness. 3. During a concurrent observation and interview on 12/16/2025 at 11:12 a.m., with the DS, observed the ice machine water filter. The ice machine water filter was labeled installed on 5/16/2025 and replace 11/16/2025. The DS validated and stated that the ice machine water filter was supposed to be changed to make sure water was filtered properly due to possible water contamination which can lead to possible foodborne illness if ingested. During a review a review of facility's P&P titled, Ice Machine and Storage Chests, revised on 1/2025, the P&P indicated, Ice machines and ice storage/distribution chests will be used and maintained per manufacturer's guidelines to ensure the safe and sanitary supply of ice. During a review of the ice machine manufacturer's instructions, undated, the ice machine manufacturer's instructions indicated, All the components and surfaces exposed to water or ice cubes, like the ice storage bin, water tank, evaporator, water pump, silicone tube, water outlet pipe, etcetera should be cleaned six (6) months after the first use. 4. During a concurrent observation, interview, and record review on 12/15/2025 at 8:31 a.m., with the Director of Maintenance (DOM), observed the residents' refrigerator. Observed chocolate milk and vanilla and chocolate ice creams not labeled with resident's name and date. The DOM stated that facility staff needs to label all the food with the resident's name and the date when it was received since they must throw away the food after three (3) days. Reviewed the residents' refrigerator temperature log which indicated missing daily temperatures for the dates of 12/12/2025, (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12/13/2025, and 12/14/2025. The DOM validated the missing refrigerator temperature checks for the three (3) days and stated that the facility was supposed to check the temperature of the residents' refrigerator and record it using the facility's Refrigerator/Freezer Temperature Log.During an interview on 12/15/2025 at 3:25 p.m., with the DS, the DS stated that it was important to check the temperature of the residents' refrigerator daily. The DS stated all food put in the residents' refrigerator should have labels with name and date when it was received, due to the possibility of food poisoning if the food was not in the proper temperature and if the food was left for too long. During a review of the facility's policy and procedure (P&P) titled, Use and storage of food brought to resident, revised on 6/2025, the P&P indicated, To ensure safe food practices and the prevention of foodborne illnesses, the facility shall provide safe and sanitary storage of food brought to residents by family and visitors for a period not to exceed 48 hours. The P&P indicated, Temperature Control of perishable (usually food, that is likely to spoil, decay or go bad) foods must be refrigerated at 41-degree Fahrenheit (unit for temperature) or below. The P&P also indicated, All food brought in should be labeled with resident name, and date delivered.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on interview and record review, the facility failed to provide a resident's representative with information regarding formulating an advance directive (AD- a legal document indicating resident preference on end-of-life treatment decisions) for one of 12 sampled residents (Resident 16).This deficient practice had the potential for Resident 16 and their representative to not be informed of their right to formulate an advance directive and not honor the resident's wishes regarding end-of-life care.Findings: During a review of Resident 16's admission Record, the admission Record indicated the facility originally admitted the resident on 1/30/2025 with diagnoses including anxiety disorder (a mental health condition where you experience excessive, persistent worry, fear, or nervousness that doesn't go away and interferes with daily life) and history of falling. During a review of Resident 16's Minimum Data Set (MDS- a resident assessment tool) dated 11/4/2025, the MDS indicated the resident`s cognitive skills for daily decision making was intact.^ The MDS further indicated that Resident 16 required partial to moderate assistance with activities of daily living (ADL- activities related to personal care).During a review of Resident 16`s History and Physical dated 1/30/2025, the H&P indicated that the resident does not have the capacity to make healthcare decisions; however able to decide for activities of daily living and able to make needs known. During a concurrent interview and record review on 12/18/2025 at 9:30 a.m., with the Social Services Director (SSD), reviewed Resident 16`s H&P 1/30/2025. The SSD stated that the AD was offered to Resident 16 but Resident 16 declined assistance. The SSD stated that he (SSD) should have offered assistance to Resident 16`s responsible party regarding formulating an AD since Resident 16 has no capacity to make health care decisions.During a review of the facility`s policy and procedure (P&P) titled, Advance Directive, last reviewed on 1/28/2025, the P&P indicated, Residents have the right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.if a resident is unable to make health care decision, a decision by the resident`s legal representative to forego treatment may, subject to State requirements, be equally binding on the facility.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and record review, the facility failed to follow a physician's order by failing to notify a resident's physician regarding a resident having signs and symptoms of bleeding for one of six sampled residents (Resident 2). This deficient practice had the potential to result in worsening symptoms and negatively affect the delivery of care and services to Resident 2.Findings: During a review of Resident 2's admission Record, the admission Record indicated the facility admitted Resident 2 on 8/14/2025 with diagnoses including ventricular fibrillation (life-threatening heart rhythm), myocardial infarction (heart attack-when blood flow to a part of the heart muscle gets blocked), and end stage renal disease (ESRD-a medical condition in which a person's kidneys [organ in the body that filters waste and excess fluid from the blood] stop functioning on a permanent basis). During review of Resident 2's Minimum Data Set (MDS - a resident assessment tool) dated 11/21/2025, the MDS indicated Resident 2 had intact cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and needed maximal assistance from staff for activities of daily living (ADLs- activities related to personal care). The MDS also indicated Resident 2 was receiving anticoagulant (medication used to treat and prevent blood clots [gel-like clumps of blood]) medication. During a review of Resident 2's Care Plan (CP- a document that summarizes a resident's needs, goals, and care/treatment) dated 8/19/2025, the CP indicated that Resident 2 was high risk for bleeding, bruising, and/or skin discoloration related to anticoagulant therapy. The CP indicated a goal that the resident will remain free of abnormal bleeding or bruising with interventions to monitor/document and report to physician for signs and symptoms of bleeding (abnormal or unexplained bruising, petechiae [tiny pinpoint sized red, purple or brown on the skin or mucous membrane], internal bleeding, nosebleeds, bleeding gums, abnormal bleeding). During a review of Resident 2's Order Summary Report, the Order Summary Report indicated the following orders:- Clopidogrel bisulfate (anticoagulant medication) 75 milligrams (mg- unit of measurement) by mouth (PO) one time a day (QD), ordered 9/5/2025.- Eliquis (anticoagulant medication) 2.5 mg PO two times a day, ordered 11/3/2025.- Eliquis and clopidogrel bisulfate: monitor signs and symptoms of bleeding (abnormal or unexpected bruising, petechiae, internal bleeding, nosebleeds, bleeding gums, abnormal bleeding) by documenting (+) yes or (-) no every shift and notify physician if (+) yes, ordered 11/28/2025.During a review of Resident 2's Medication Administration Record (MAR, a report detailing the medications administered to a resident by the licensed nurse in the facility), the MAR indicated a (+) yes for signs and symptoms of bleeding on the following dates and shifts: - 12/6/2025, 7 am-3 pm shift. - 12/13/2025, 7 am-3 pm, 3 pm-11 pm, and 11 pm-7 am shifts. - 12/14/2025, 7 am-3 pm, 3 pm-11 pm, and 11 pm-7 am shifts. - 12/15/2025, 7 am-3 pm, 3 pm-11 pm, and 11 pm-7 am shifts. - 12/16/2025, 7 am-3 pm, 3 pm-11 pm, and 11 pm-7 am shifts. During a concurrent interview and record review on 12/17/2025 at 10:53 a.m., with Registered Nurse 1 (RN 1), reviewed Resident 2's progress notes and Situation, Background, Assessment, Recommendation (SBAR- a form filled out by licensed nursing staff for the purpose of communicating information about a resident's condition or other issue to other members of the health care team, including a resident's doctor). Resident 2's progress notes and SBAR indicated there was no documentation regarding any signs and symptoms of bleeding and no documentation indicating Resident 2's physician was notified. RN 1 stated that since staff documented that Resident 2 has been having signs and symptoms of bleeding, the staff have to notify the physician and document on the resident's progress notes and/or SBAR. RN 1 also stated that it is important to monitor for signs and symptoms of bleeding and notify Resident 2's physician since Eliquis and clopidogrel bisulfate are high risk medications. During an interview on 12/17/2025 at 11:15 a.m., with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated Resident 2 had some multiple bruising/ skin discolorations on the left upper chest and left upper arm since admission. LVN 1 stated they were not aware that Resident 2 had some new bruising since staff recently had been (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documenting (+) yes for signs and symptoms of bleeding. LVN 1 stated that if there was any signs and symptoms of bleeding, per the physician order, staff need to report to the physician and document since Resident 2 is high risk for bleeding due to his anticoagulant medication use. During a review of the facility's policy and procedure (P&P) titled, Anticoagulation Clinical Protocol, revised on 1/2025, the P&P indicated, Facility provides care and services consistent with current standards of practice for residents who use anticoagulants. The P&P also indicated, If an individual on anticoagulation therapy shows signs of bruising, hematuria, hemoptysis, or other evidence of bleeding, the nurse will discuss the situation with the physician before giving the next scheduled dose of anticoagulant.During a review of the facility's P&P titled, Documentation Policy, revised on 1/2025, the P&P indicated, Physician communications as required by regulations (unless using the SBAR form) or additional communications that may arise regarding physician communications should be under what can or should be charted in nursing or other notes.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review, the facility failed to notify the State Long-Term Care (LTC) Ombudsman (advocates for residents of nursing homes, board and care homes, and assisted living facilities) of a resident's discharge from the facility for one of three sampled residents (Resident 54). This deficient practice had the potential for the ombudsman to not be aware of any potential issues from the discharge.Findings:During a review of Resident 54's admission Record, the admission Record indicated the facility initially admitted Resident 54 on 9/12/2025 with diagnoses including difficulty walking, nicotine dependence (a chronic, compulsive need for nicotine [found in tobacco, cigarettes]), and anxiety disorder (a mental health condition where you experience excessive, persistent worry, fear, or nervousness that doesn't go away and interferes with daily life).During a review of Resident 54's History and Physical (H&P) dated 9/13/2025, the H&P indicated Resident 54 did have the capacity to make medical decisions. During a review of Resident 54's Minimum Data Set (MDS - a resident assessment tool) dated 9/17/2025, the MDS indicated Resident 54 could make herself understood and could understand others. The MDS indicated Resident 54 was independent when eating and required partial assistance from facility staff for activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily).During a review of Resident 54's Discharge Summary progress note dated 11/11/2025, the progress note indicated Resident 54 was discharged on 11/11/2025 back to her home at an assisted living facility with all of her belongings and discharge instructions.During a concurrent interview and record review on 12/18/2025 at 9:17 a.m., with the Social Services Director (SSD), reviewed Resident 54's Notice of Transfer form dated 11/11/2025. The SSD stated Resident 54 initiated the discharge on ce her intravenous (IV- medication administered through a vein) antibiotic therapy (medication to treat a bacterial infection) was complete. The SSD stated he (SSD) gave the Notice of Transfer form to Resident 54 but never faxed the form to the Ombudsman because he was advised by the Director of Nursing (DON) that faxing the Notice of Transfer to the Ombudsman is not necessary when the resident initiates the discharge. The SSD stated the DON was out on leave.During an interview on 12/18/2025 at 12:04 p.m., with Registered Nurse 3 (RN 3), RN 3 stated she (RN 3) and another RN had been assisting with DON duties while the DON was on leave. RN 3 stated the Ombudsman should have been notified just in case there was a concern.During a review of the facility's policy and procedure (P&P) titled, Documentation of Discharge or Transferring a Resident, last reviewed 1/2025, indicated the facility will forward a copy of the notices of transfer to the Ombudsman.

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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 a resident's indwelling urinary catheter (a tube that is inserted into the bladder, allowing urine to drain) tubing was not coiled and allowed the contents to flow freely into the urinary catheter bag (container that connects to a urinary catheter and collects urine) for one of one sampled resident's (Resident 9).This deficient practice had the potential for Resident 9 to develop a urinary tract infection (UTI- an infection in the urinary system). Findings: During a review of Resident 9's admission Record, the admission Record indicated the facility admitted Resident 9 on 10/20/2025 with diagnoses including urinary tract infections, neuromuscular disfunction of the bladder (a condition where the nerves that control the bladder are damaged, preventing it from emptying properly), and chronic kidney disease (a long-term condition where the kidneys are damaged and gradually lose their ability to filter blood properly). During a review of Resident 9's History and Physical (H&P) dated 11/3/2025, the H&P indicated the resident did not have the capacity to make decisions or needs known. During a review of Resident 9's Minimum Data Set (MDS - a resident assessment tool) dated 11/14/2025, the MDS indicated Resident 9 can sometimes make self-understood and can sometimes understand others. During a review of Resident 9's Order Summary Report, the Order Summary Report indicated Resident 9 had an order for an indwelling catheter #FR 16 (French, 16 is the size of the tubing) x 10 milliliter (ml- a unit of volume measurement) to drainage bag due to diagnosis of neurogenic bladder, ordered 10/21/2025.During a review of Resident 9's Care Plan (CP- a document that summarizes a resident's needs, goals, and care/treatment) for at Risk for UTI dated 10/20/2025, the CP indicated an intervention to check the tubing for kinks each shift. During an observation on 12/15/2025 at 9:08 a.m., inside Resident 9's room, observed Resident 9 lying down in bed with a urinary catheter bag hanging on the left side of Resident 9's bed frame. Observed the urinary catheter tubing hung below the middle-left side of the bed and had coils with a kink. The coiled portion of the urinary catheter tubing contained yellow liquid. During a concurrent observation and interview on 12/15/2025 at 9:16 a.m., inside Resident 9's room, with Licensed Vocational Nurse 1 (LVN 1), observed Resident 9's urinary catheter tubing. LVN 1 stated Resident 9's urinary catheter tubing was coiled and contained yellow liquid. LVN 1 stated the urinary catheter tubing should be straight and without kinks in order to drain the urine into the urinary catheter bag. LVN 1 further stated Resident 9 had a history of UTI's and if the urine is not draining properly, the resident could get an infection. During an interview on 12/18/2025 at 12:34 p.m., with Registered Nurse 3 (RN 3), RN 3 stated the urinary catheter tubing should not be coiled or kinked and should be below the bladder level. RN 3 stated that if the urinary catheter tubing is coiled, it can possibly become kinked leading to back flow and possible infection. During a review of the facility's policy and procedure (P&P) titled, Indwelling Catheter Use, last reviewed 1/2025, the P&P indicated the policy of the facility is to provide catheter care to reduce the risk of infections and to position the tubing lower than the body to facilitate drainage. During a review of the facility-provided indwelling catheter insert directions, not dated, the insert indicated to maintain unobstructed free flow of the catheter and tubing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555519	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Care Center on Hazeltine, LLC	6835 Hazeltine Ave. Van Nuys, CA 91405

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to store medications in accordance with manufacturer specifications, professional principles and facility policy and procedures, in one (1) of two (2) inspected medication carts (Medication Cart 1) by failing to ensure eye drops were stored separately from orally administered medications.This deficient practice had the potential to increase the risk of infections for residents in the facility and to receive medications in the wrong route (internal versus external routes) possibly leading to adverse health consequences. Findings: During a concurrent observation and interview on 12/16/2025 at 10:18 a.m. with Licensed Vocational Nurse (LVN) 3, in Medication Cart 1, the following medications were stored in a manner contrary to the facility's P&P:a. One (1) eye drop solution stored with sodium chloride oral tablet, glucosamine oral capsule and oyster shell calcium oral tablets in the same bin of the medication cart.LVN 3 stated that orally administered medications and eye drops should be stored separately in their own sections/bins, not together, to prevent errors in wrong route administration. LVN 3 stated the eye drop solution should have been separated from sodium chloride oral tablet, glucosamine oral capsule and oyster shell calcium oral tablets. During an interview on 12/16/2025 at 3 p.m. with the Assistant Director of Nursing (ADON), ADON stated internally (such as oral, intravenous) and externally (such as eyes, ears, nose, skin) administered medications should be stored separately to prevent wrong route administration, infections and contaminations. The DON stated the facility failed to store eye drops in Medication Cart 1 separately from the oral medications such as sodium chloride oral tablet, glucosamine oral capsule and oyster shell calcium oral tablets. During a review of the facility's Policies and Procedures (P&P,) titled Pharmaceutical Services - Labeling and Storage, last reviewed 1/28/2025, the P&P indicated: Externally used drugs in liquid, tablet, capsule or powder form shall be stored separately from drugs for internal use.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555519	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Care Center on Hazeltine, LLC	6835 Hazeltine Ave. Van Nuys, CA 91405

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 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 observation, interview, and record review, the facility failed to ensure a resident's water pitcher was not placed on the floor for one of one sampled resident (Resident 16).This deficient practice had the potential to result in contamination of the drinking water that can lead to waterborne diseases caused by pathogens (bacteria, viruses, parasites) spread through contaminated water, leading to symptoms like diarrhea and vomiting. Findings: During a review of Resident 16's admission Record, the admission Record indicated the facility originally admitted the resident on 1/30/2025 with diagnoses including anxiety disorder (a mental health condition where you experience excessive, persistent worry, fear, or nervousness that doesn't go away and interferes with daily life) and history of falling. During a review of Resident 16's Minimum Data Set (MDS- a resident assessment tool) dated 11/4/2025, the MDS indicated the resident`s cognitive skills for daily decision making was intact.^ The MDS further indicated that Resident 16 required partial to moderate assistance with activities of daily living (ADL- activities related to personal care).During an observation on 12/15/2025 at 11:15 a.m., observed two (2) water pitchers on the floor by Resident 16's bedside while the resident was in bed sleeping. During a concurrent observation and interview on 12/15/2025 at 12:09 p.m., with the Director of Staff Development/Infection Preventionist Nurse (DSD/IPN), the DSD/IPN stated that residents' water pitchers are replaced twice a day and when staff bring in the pitchers it must be placed on the clean nightstand or bedside table. The DSD/IPN confirmed by stating that two water pitchers were on the floor by Resident 16's bedside. The DSD/IPN stated that the water pitchers should not be on the floor since the floor is considered a dirty surface and the content of the water pitchers can get contaminated which can result in the residents getting sick with waterborne diseases. During a review of the Centers for Disease Control and Prevention (CDC, national public health agency) source material, Guidelines for Environmental Infection Control in Health-Care Facilities, updated 7/2019, indicated floors can become rapidly contaminated from airborne microorganisms and those transferred from shoes, equipment wheels, and body substances.