STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555716	A. Building B. Wing	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park View Nursing and Subacute	6740 Wilbur Ave Opco, LLC Reseda, CA 91335

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on interview and record review, the facility failed to ensure a grievance submitted on behalf of a resident's family member was addressed and investigated per the facility's policy and procedure (P&P) for one of two sampled residents (Resident 1). This deficient practice violated the resident's right to have their grievance addressed and had the potential for further concerns to not be addressed. Findings: During a review of Resident 1's admission Record, the admission Record indicated that the facility admitted Resident 1 on 2/17/2026 with diagnoses that included but not limited to cerebral infarction (stroke, loss of blood flow to a part of the brain resulting in damage to brain tissue), diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing), and hypertension (high blood pressure [the force of the blood pushing on the blood vessel walls is too high]). During a review of Resident 1's Minimum Data Set (MDS -a resident assessment tool) dated 2/23/2026, the MDS indicated that Resident 1's cognition (ability to think, reason, and function) was intact. The MDS indicated Resident 1 was independent with oral hygiene and required moderate assistance with toileting, showering and upper and lower body dressing. During a concurrent interview and record review on 3/24/2026 at 9:17 a.m., with the Social Services Director (SSD), reviewed the facility's grievance binder dated 1/2026 to 3/2026. The grievance binder indicated there was no record of grievance filed for Resident 1. The SSD stated that if the facility receives concerns or complaints from staff or residents, a grievance form should be filled out by the staff member who received the complaint and should communicate with the social services department personnel to follow up and document. The SSD stated the grievance should be logged into the grievance binder. During a concurrent interview and record review on 3/24/2026 at 10:55 a.m., with the Director of Nursing (DON), reviewed the facility's grievance binder dated 1/2026 to 3/2026. The grievance binder indicated there was no record of grievance filed for Resident 1. The DON stated she has not received any complaint or grievance letter from Resident 1's family. The DON stated that all complaints should be documented in the grievance binder. The DON stated the Administrator (ADM), the DON, and the SSD are the designated grievance coordinators and should be informed regarding a grievance and an investigation should be started right away. During a telephone interview on 3/24/2026 at 1:26 p.m., with Family Member 1 (FM 1), FM 1 stated an email was sent to the facility on 2/27/2026 regarding a grievance of Resident 1's family's concerns for Resident 1's care while in the facility. FM 1 stated an email was received from the ADM on 2/27/2026 at 3:45 p.m. indicating that the ADM had received the email. FM 1 stated no one from the facility has informed the family what the facility has done to address Resident 1's family's grievances. During a concurrent interview and record review on 3/25/2026 at 8:41 a.m., with the ADM, reviewed the facility's P&P titled, Grievance/Concern, last revised for 1/2026 - 1/2027. The ADM stated she (ADM) received an email regarding Resident 1's family's concerns for Resident 1's care while in the facility on 2/27/2026. The ADM stated that ADM did not put Resident 1's family's concerns on the grievance form and the facility did not initiate the investigation until that day, 3/25/2026. The ADM further stated an investigation should have been done as soon as possible to let Resident 1's family know what the facility has done to address Resident 1's family's concerns. During a review of the facility's (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	P&P titled, Grievance/concern, last revised for 1/2026 - 1/2027, the P&P indicated, Upon receipt of the grievance/concern, the grievance/concern form will be initiated by the staff member receiving the concern and documented on the grievance/concern log. During a review of the facility's P&P titled, Resident Rights,, last revised for 1/2026 - 1/2027, the P&P indicated, 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to . voice grievances to the facility, or other agency that hears grievances, without discrimination or reprisal and without fear of discrimination or reprisal; have the facility respond to their grievances.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on interview and record review, the facility failed to provide a summary of a resident's baseline care plan (a document that summarizes a resident's needs, goals, and care/treatment) to a resident and/or their representative for one of two sampled residents (Resident 1). This deficient practice had the potential to negatively affect the residents' care.Findings: During a review of Resident 1's admission Record, the admission Record indicated that the facility admitted Resident 1 on 2/17/2026 with diagnoses that included but not limited to cerebral infarction (stroke, loss of blood flow to a part of the brain resulting in damage to brain tissue), diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing), and hypertension (high blood pressure [the force of the blood pushing on the blood vessel walls is too high]). During a review of Resident 1's Minimum Data Set (MDS -a resident assessment tool) dated 2/23/2026, the MDS indicated that Resident 1's cognition (ability to think, reason, and function) was intact. The MDS indicated Resident 1 was independent with eating and oral hygiene, and required moderate assistance with toileting, showering and upper and lower body dressing. During a review of Resident 1's Interdisciplinary Care Conference (ICC - a meeting where a resident's entire healthcare team comes together to create one unified, comprehensive plan for the resident's care) notes dated 2/18/2026, the ICC notes indicated that the box for Copy of the care plan was provided to the resident/resident representative was not marked and left blank. During a concurrent interview and record review on 3/24/2026 at 4:03 p.m., with the Case Manager (CM), reviewed Resident 1's ICC notes dated 2/18/2026. When the CM was asked if the CM provided a baseline care plan written summary to Resident 1 or Resident 1's family, the CM stated that the CM could not recall if it was provided or not and needed to check documents. The CM returned and stated that the CM was unable to locate documents indicating that the CM provided the baseline care plan written summary to Resident 1 and/or Resident 1's family. During a concurrent interview and record review on 3/25/2026 at 10:18 a.m., with the Director of Nursing (DON), reviewed Resident 1's ICC notes dated 2/18/2026. The DON stated that the facility should develop a baseline care plan within 48 hours of a resident's admission and provide a written summary of baseline care plan to the resident and/or the resident's family. The DON further stated that Resident 1's ICC notes dated 2/18/2026 indicated that it was not marked if the facility had provided copies of Resident 1's care plan to Resident 1 and/or Resident 1's representative. The DON reviewed Resident 1's clinical records but could not locate the information indicating Resident 1's written baseline care plan summary was provided to Resident or Resident 1's family. The DON reviewed the facility's policy and procedure (P&P) for baseline care plan and stated that the P&P did not indicate to provide a written summary of the baseline care plan to the resident or family, but the copies of the baseline care plan summary should be provided to the resident or resident's family. During a review of the facility's P&P titled, Care Plan - Baseline, last revised for 1/2026 - 1/2027, the P&P indicated, A baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care shall be developed and implemented for each resident by the Interdisciplinary Team (IDT- a group of health care professionals with various areas of expertise who work together toward the goals of the residents' care plan). The baseline care plan is developed within 48 hours of a resident's admission.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to ensure proper use of a low air loss mattress (LALM - a specialty bed that alternates pressure to help heal and prevent pressure ulcer/injuries [PU/PI- injuries that breakdown the skin and underlying tissue when an area of skin is placed under pressure]) by placing multiple layers of linens on top of the LALM for one of thirteen sampled residents (Resident 2). This deficient practice had the potential to increase the resident's risk of skin breakdown and/or delayed healing of existing PU/PI.Findings: During a review of Resident 2's admission Record, the admission Record indicated that the facility admitted Resident 2 on 3/17/2026 with diagnoses that included osteoarthritis (a degenerative joint disease where the cartilage that cushions the ends of bones gradually wears away, leading to pain, stiffness, and reduced movement) left knee, presence of left artificial knee joint, and pressure ulcer of sacral (refers to the lower back area right above the buttocks) region, stage III (deep wound where the skin is completely gone where the underlying fat tissue may be visible). During a review of Resident 2's Minimum Data Set (MDS -a resident assessment tool) dated 3/23/2026, the MDS indicated that Resident 2's cognition (ability to think, reason, and function) was intact. During a review of Resident 2's Facility admission body check notes dated 3/18/2026, the notes indicated Resident 2 had a sacrococcyx (the area at the base of the spine near the tailbone) stage III PI with a measurement as follows: Length - four (4) centimeters (cm - unit of measurement), width - 0.5 cm, and depth - 0.1 cm. During a review of Resident 2's Order Summary Report, the Order Summary Report indicated an order for LALM: settings based on resident's comfort and /or weight and to monitor for proper settings and functionality, ordered 3/18/2026. During a review of Resident 2's Care Plan (CP- a document that summarizes a resident's needs, goals, and care/treatment) dated 3/18/2026, the CP indicated Resident 2 had a sacrococcyx stage III PI. The CP indicated Resident 2 would not have any further skin breakdown by monitoring LALM in correct setting. During a concurrent observation and interview on 3/24/2026 at 8:35 a.m., with Certified Nursing Assistant 1 (CNA 1) and CNA 2, observed Resident 2 lying on a LALM. Observed Resident 2 wearing an incontinence (loss of bowel or bladder control) brief and had a flat sheet with a cloth incontinence linen pad. CNA 1 stated Resident 2 was on LALM due to an open wound on Resident 2's bottom. CNA 1 stated there are a total of four layers of linen placed underneath Resident 2. CNA 1 stated there should only be one layer of linen placed between the resident's skin and LALM. During an interview on 3/25/2026 at 9:25 a.m., with the Director of Staff Development (DSD), the DSD stated that for residents on LALM, only flat sheets should be used and staff should use the disposable pads or an incontinence brief but not use both at the same time. The DSD stated there should be no more than two layers of linen between the bed and the resident for the LALM to work appropriately. The DSD stated the LALM works by pushing air out, keeping residents dry preventing skin breakdown due to moisture, and helps promote wound healing. During an interview on 3/25/2026 at 10:27 a.m., with the Director of Nursing (DON), the DON stated LALM are used primarily for skin management. The DON stated staff should not use more than two layers of linen because it would defeat the purpose of LALM use and would delay wound healing. The DON stated the facility does not have a policy and procedure on LALM use. During a review of the facility's policy and procedure (P&P) titled, Pressure ulcers/skin breakdown - clinical protocol, revised for 1/2026 - 1/2027, the P&P indicated, The physician will order pertinent wound treatments, including pressure reduction surfaces, wound cleansing and debridement approaches, dressings, and application of topical (a medication that is applied to a particular place on or in the body) agents.

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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. Based on interview and record review, the facility failed to ensure Registered Nurse 1 (RN 1) documented on a resident's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications given to a resident) right after administering insulin (hormone that regulates the amount of glucose [sugar] in the blood) lispro (rapid-acting insulin) for one of two sampled residents (Resident 1). This deficient practice had the potential to result in medication errors and negatively affect the delivery of care and services to Resident 1.Findings: During a review of Resident 1's admission Record, the admission Record indicated that the facility admitted Resident 1 on 2/17/2026 with diagnoses that included but not limited to cerebral infarction (stroke, loss of blood flow to a part of the brain resulting in damage to brain tissue), diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing), and hypertension (high blood pressure [the force of the blood pushing on the blood vessel walls is too high]). During a review of Resident 1's Minimum Data Set (MDS -a resident assessment tool) dated 2/23/2026, the MDS indicated that Resident 1's cognition (ability to think, reason, and function) was intact. The MDS indicated Resident 1 was independent with eating and oral hygiene, and required moderate assistance with toileting, showering and upper and lower body dressing. During a review of Resident 1's Order Summary Report, the Order Summary Report indicated an order for insulin lispro inject as per sliding scale (progressive increase in the insulin dosage, based on pre-defined blood glucose ranges), subcutaneously (SQ - administering medication where a short needle is used to inject a medication into the tissue layer between the skin and the muscle) before meals and at bedtime for DM, ordered 2/17/2026. During a review of Resident 1's MAR dated 2/2026, the MAR indicated RN 1 documented insulin lispro administration on the following dates:- On 2/20/2026, insulin lispro was scheduled at 4:30 p.m., but documented as administered at 6 p.m.- On 2/21/2026, insulin lispro was scheduled at 4:30 p.m., but documented as administered at 6:19 p.m.- On 2/21/2026, insulin lispro was scheduled at 9 p.m., but document as administered at 10:04 p.m.- On 2/22/2026, insulin lispro was scheduled at 4:30 p.m., but documented as administered at 6:06 p.m. During a concurrent phone interview and record review on 3/24/2026 at 3:19 p.m., with RN 1, reviewed Resident 1's MAR for insulin lispro for 2/2026 that was documented by RN 1. RN 1 stated that RN 1 always administered Resident 1's insulin lispro on the scheduled time but documented those administrations late. RN 1 stated in general the facility provides dinner at around five (5) p.m., so RN 1 would check the resident's blood sugar about 30 minutes before mealtime, then would administer insulin lispro right before eating dinner, but RN 1 documented late. RN 1 stated that RN 1 should document right after administering the medication, especially for insulin, because the time of administration was sensitive with mealtime and blood sugar level monitoring. During a concurrent interview and record review on 3/25/2026 at 10:11 a.m., with the Director of Nursing (DON), reviewed Resident 1's MAR dated 2/2026 for insulin lispro. The DON stated that the licensed nurses should document right after administering all the medications. During a review of the facility's policy and procedure (P&P) titled, Medication Administration - General Guidelines, last revised for 1/2026 - 1/2027, the P&P indicated, Medications are administered within 60 minutes of scheduled time (one hour before and one hour after), except before or after meal orders. The individual who administers the medication dose records the administration on the resident's MAR directly after the medication given. At the end of each medication pass, the person administering the medications reviews the MAR to ensure necessary doses were administered and documented.

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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 the use of a low air loss mattress (LALM - a specialty bed that alternates pressure to help heal and prevent pressure ulcer/injuries [PU/PI - injuries that breakdown the skin and underlying tissue when an area of skin is placed under pressure]) for 12 of 12 sampled residents (Resident 2, Resident 3, Resident 4, Resident 5, Resident 6, Resident 7, Resident 8, Resident 9, Resident 10, Resident 11, Resident 12 and Resident 13) reviewed for PU/PI prevention. This deficient practice resulted in inconsistent use of the LALM and had the potential to compromise its effectiveness placing residents at risk for skin breakdown and/or delayed healing of PU/PI.Findings: During a review of the facility's Order Listing Report dated 3/25/2026, the Order Listing Report indicated the following:- Resident 2 had an order for LALM dated 3/18/2026.- Resident 3 had an order for LALM dated 1/3/2026.- Resident 4 had an order for LALM dated 4/11/2025.- Resident 5 had an order for LALM dated 10/16/2025.- Resident 6 had an order for LALM dated 3/13/2026.- Resident 7 had an order for LALM dated 3/5/2026.- Resident 8 had an order for LALM dated 3/13/2026.- Resident 9 had an order for LALM dated 1/1/2025.- Resident 10 had an order for LALM dated 3/9/2026.- Resident 11 had an order for LALM dated 8/4/2025.- Resident 12 had an order for LALM dated 11/25/2025.- Resident 13 had an order for LALM dated 11/27/2025. During a concurrent observation and interview on 3/25/2026 at 9:32 a.m., with Treatment Nurse 1 (TN 1), TN 1 stated there were a total of 12 residents that were using LALM. Resident 2, Resident 3, Resident 4, Resident 5, Resident 6, Resident 7, Resident 8, Resident 9, Resident 10, Resident 11, Resident 12, and Resident 13 were observed to be on LALM. TN 1 stated LALM were being used to prevent pressure ulcers and to promote wound healing for residents who have pressure ulcers. During an interview on 3/25/2026 at 10:27 a.m. with the Director of Nursing (DON), the DON stated the facility does not have a policy and procedure (P&P) for residents' use of LALM including use of linen with LALM, and the facility followed manufacturer's guidelines. The manufacturer 's guidelines provided by the DON did not indicate linen use with LALM. The DON stated the facility will develop P&P on LALM use.During an interview on 3/25/2026 at 10:57 a.m., with the Administrator (ADM), the ADM stated the facility should have a P&P for LALM use to have guidance on how to manage residents that were on LALM. The ADM further stated that the facility had a lot of residents with LALM use. During a review of the facility's DON job description revised 7/2024, the job description indicated, Develop and maintain nursing P&P that conform to current standards of nursing practice, facility mission and state and federal regulations. During a review of the facility's ADM job description revised 7/2024, the job description indicated, Ensure the planning, development, implementation and monitoring of facility P&P.