STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056092	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Topanga Terrace	22125 Roscoe Blvd Canoga Park, CA 91304

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.

38469

Based on interview and record review, the facility failed to:

1. Develop a comprehensive person-centered care plan (a plan for an individual's specific health needs and desired health outcomes) addressing the resident`s vision impairment (occurs when an eye condition affects the visual system and its vision functions) for one of one sampled resident (Resident 93).

2. Develop individualized person-centered care plan for insulin (a medication used in the treatment and management of diabetes mellitus[DM- a disease that occurs when the sugar level is high in the blood]) use for one of ten sampled residents (Resident 67).

These deficient practices had the potential to result in failure to deliver the necessary care and services for Resident 93 and had the potential to lead to the inadequate care of Resident 67.

Findings:

a. During a review of Resident 93's Admission Record, the Admission Record indicated the facility admitted the resident on 8/26/2024 with diagnoses that included depression (characterized by a prolonged low mood and loss of interest in activities that used to be enjoyable) and chronic respiratory failure (shortness of breath or feeling like you can't get enough air, extreme tiredness, an inability to exercise as you did before, and sleepiness).

During a review of Resident 93's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 9/01/2024, the document indicated the resident's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was intact and the resident was dependent on staff for toileting, shower, lower body dressing, and putting on and taking off footwear.

During an interview and record review with Licensed Vocational Nurse 1 (LVN 1) on 10/23/24 at 11:29 a.m., Resident 93`s Social Services-Admission-Evaluation (SSAE) notes, which indicated that the resident was visually impaired was reviewed. Upon assessment and confirmation by LVN1 of the resident`s visual functioning, at the resident`s bedside, the resident was unable to count how many of LVN 1`s finger was in front of her face with 1 1/2 feet distance. The resident stated she could not see the LVN`s hand and could only see the shadow of the LVN 1`s face.

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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: 056092	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER Topanga Terrace		STREET ADDRESS, CITY, STATE, ZIP CODE 22125 Roscoe Blvd Canoga Park, CA 91304	

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow up interview with LVN1 on 10/24/24 at 8:56 p.m., LVN1 stated that the Social Services staff that did the assessment should have discussed, with the nurses, the resident`s complaint of visual impairment. LVN1 stated that there should have been a Change of Condition (COC) triggered to further assess the resident and identify the risks and care needs of a visually impaired resident. LVN1 stated that a Care Plan should have been initiated upon identification of the resident`s visual impairment and development of a goal of treatment and outline interventions to achieve the goals. LVN1 stated that without a care plan for visual impairment, the resident`s care needs cannot not be met and could result in the resident`s becoming depressed about her situation. During a record review and concurrent interview with the Social Services Director (SSD) on 10/24/24 at 10:09 a.m., Resident 93's Social Services-Admission Evaluation (SSAE) dated 9/2/2024 was reviewed. The SSD stated that in the section Psychosocial Evaluation, it indicated that the resident is visually impaired. The SSD stated that Resident 93 had told her that her vision is a little off. The SSD stated that she had informed the nurse about the resident`s vision problem but was unable to remember who was the nurse that she spoke to. Also reviewed with the SSD, the Resident 93`s Care Conference-Interdisciplinary, dated 9/3/2024. The SSD stated that she did not mention the resident`s complaint about her vision to the Interdisciplinary Team (a group of health care professionals with various areas of expertise who work together toward the goals of their clients), and nothing was discussed in this care conference the resident`s complaint about her vision problem. During a review of the facility`s policy on Interdisciplinary Team Guidelines, Care Planning, last reviewed on January 2024, the policy indicated that it is the policy of the facility to include appropriate members of the IDT in the care planning process to effectuate, as appropriate, person-centered care . 44309 b. During a review of Resident 67`s Admission Record, the Admission Record indicated that the facility admitted the resident on 9/30/2024, with diagnoses including type two (2) DM, muscle weakness, and retention of urine (a condition in which you are unable to empty all the urine from your bladder). During a review of Resident 67's Minimum Data Set (MDS - a comprehensive assessment and care screening tool) dated 10/6/2024, the document indicated that the resident`s cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was intact (decisions consistent/reasonable). The MDS indicated that Resident 67 was dependent on staff (helper does all of the effort) for toileting hygiene, showering and bathing, lower body dressing, and required staff supervision when eating. The MDS further indicated that Resident 67 received seven (7) insulin injections within the last seven days/since admission. (continued on next page)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 67`s Physician order dated 9/30/2024, the document indicated to administer insulin lispro (a rapid-acting insulin: a medicine used to control the amount of sugar in the blood of patients with diabetes. It starts to work very quickly, and you take it before meals to stop your blood sugar (BS) from going too high) subcutaneously (SQ- to inject under all the layers of the skin) as per sliding scale (the increasing administration of the insulin dose based on the blood sugar level before the meal): if a resident`s blood sugar level is 70-150 milligrams per deciliter (mg/dl-unit of measurement [normal range for a diabetic according to American Diabetes Association: 80-130 mg/dl]) administer 0 unit of insulin (a unit of measurement for insulin), BS 151-200 mg/dl=2 units, BS 201-250 mg/dl=3 units, BS 251-300 mg/dl= 4 units, BS 351-400 mg/dl=5 units, and if the BS level is more than 400 mg/dl administer 6 units of insulin and notify the physician. During a review of Resident 67`s Medication Administration Record (MAR-a record of medications administered to residents) for the months of September and October 2024, the document indicated that the licensed staff checked Resident 67 `s BS level and followed the insulin lispro sliding scale instructions for administration of the medication from 9/30/2024 to 10/15/2024. During a review of Resident 67`s Nursing Progress Notes dated 10/15/2024 at 2:05 p.m., the document indicated that both Resident 67 and a family member requested that BS level checks and the administration of insulin are discontinued. The Note further indicated that the licensed staff contacted Resident 67`s physician and received authorization to discontinue the BS level checks and the administration of insulin. During a review of Resident 67`s Care Plan dated 10/18/2024, the document indicated that the resident had non-insulin dependent DM2.  Further review of the care plans indicated that there was no individualized person-centered care plan including measurable objectives, goal, and monitoring before 10/18/2024, for Resident 67`s insulin consumption and her refusal for BS level checks. During a concurrent interview and record review on 10/23/2024 at 10:51 a.m., with the Director of Nursing (DON), Resident 67`s care plans, MAR for September and October 2024, and physician orders were reviewed. The DON stated licensed staff developed a care plan for Resident 67`s diagnoses of diabetes on 10/18/2024. However, licensed staff did not develop a care plan with goal and interventions prior to 10/18/2024, for Resident 67`s insulin use. The DON stated Licensed staff were required to initiate a care plan with goal and interventions for Resident 67`s insulin use. They should have mentioned that Resident 67 and her family member refused BS level checks and insulin injections. The DON stated the potential outcome of not developing a care plan for insulin is the lack of monitoring and delivery of necessary services. During a review of the facility`s policy and procedure titled Interdisciplinary Team (IDT, - a group of healthcare professionals from different disciplines [nurses, social worker, therapist, physician, etc.] that provide care for the residents) Guidelines, Care Planning, reviewed January 2024, the policy indicated that it is the policy of this facility to include appropriate members of IDT in the care planning process to effectuate as appropriate, person centered care. The IDT will allow the resident and/or representative to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care and any other factors related to effectiveness of the plan of care as they desire. Care plans shall include resident`s strengths, goals, life history and preferences.

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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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38469 Based on observation, interview, and record review, the facility failed to ensure residents were provided a communication device or board (a tool that includes pictures that help residents communicate their healthcare and every-day needs to facility staff) at their bedsides in the language that the residents were able to understand for two of four sampled residents (Resident 22 and Resident 350). These deficient practices prevented the residents from communicating with the staff and had the potential to delay receiving care/treatment the residents needed. Findings: a. During a review of Resident 22's Admission Record, the Admission Record indicated the facility originally admitted the resident on 02/13/2023, and readmitted on [DATE], with diagnoses including dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life) and dysphagia (difficulty swallowing). During a review of the Minimum Data Set (MDS - a standardized assessment and care screening tool) dated 9/11/2024, the MDS indicated Resident 22`s preferred language was not English and need an interpreter to communicate with a doctor or health care staff. The MDS indicated that Resident 22 had the ability to make usually makes self-understood and had the ability to understand others. The MDS indicated Resident 22 required partial assistance with toileting hygiene, upper body dressing, putting on and taking off footwear and personal hygiene. During a room observation and concurrent interview on 10/22/24 at 7:52 a.m. with Registered Nurse 1 (RN1), observed that there was no communication board at the resident`s bedside which was confirmed by RN1. RN1 stated that non-English speaking residents have to be provided with a communication board in their own language to facilitate communication between the staff and the residents. RN1 stated that with a communication board the resident would be able to communicate their needs to the staff and it would be frustrating for the residents if they are not understood thereby their needs will not be met. During a review of Resident 22`s Care Plan (a document that outlines how a patient's health care needs will be met) dated 9/3/2024, the care plan indicated that the resident has a communication problem, and the goal is for the resident to maintain current level of communication function by using appropriate gestures, responding to yes or no questions appropriately using communication board through the review date. (continued on next page)

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F 0676

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

During a review of the facility`s policy and procedures titled Limited English Proficiency, last reviewed on January 2024, the policy indicated that, the facility will take reasonable steps to ensure that all persons with Limited English Proficiency have meaningful access and an equal opportunity to participate in our services, activities, and programs . all interpreters, translators and other aids needed to comply with this policy shall be provided without cost to the person being served and patients/participants/residents and their families will be informed of the availability of such assistance at point of ministry or program access and that it is available free of charge .

44309

b. During a review of Resident 350's Admission Record, the Admission Record indicated that the facility admitted the resident on 10/18/2024, with diagnoses including type two diabetes mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), difficulty in walking, and spinal stenosis (narrowing of one or more spaces within your spinal canal [backbone]).

During a review of Resident 350`s physician History and Physical (H&P) dated 10/21/2024, the document indicated that the resident was able to give informed consent (a process in which patients are given important information, including possible risks and benefits, about a medical procedure or treatment) regarding his medical/physical treatment relating to an existing and continuing medical condition. The H&P further indicated that Resident 350 is competent (having the necessary ability) to enter into a contract including admission agreement.

During a review of Resident 350's Care Plan dated 10/21/2024, the care plan indicated that the resident had a communication problem due to a language barrier. The care plan indicated that Resident 350 speaks Armenian, Russian, Greek, and Turkish and knows very little English. The care plan goal was for the resident to be able to communicate basic needs through the review period. The care plan interventions were to provide a translator as necessary to communicate with the resident, to encourage the resident to continue verbalizing his thoughts, and to focus on a word or phrase that makes sense or responds to the feeling resident is trying to express. The care plan interventions further indicated that the resident is able to communicate by: using communication board, gestures (a movement of part of the body, especially a hand or the head, to express an idea or meaning), signs, translator.

During a concurrent observation and interview on 10/21/2024 at 10:03 a.m., inside Resident 350's room, Resident 350 was observed on his bed lying on his side. Certified Nursing Assistant 2 (CNA 2) was present at the resident`s bedside. CNA 2 stated Resident 350 speaks Farsi. He is confused, and I cannot understand him because he does not speak English well. CNA 2 stated for residents who do not speak English well, a communication board is required to be present at their bedside. CNA 2 then started searching for the communication board inside Resident 350`s room and outside on his wheelchair. However, she was unable to find one. Resident 350 stated that he speaks Armenian and Russian, and he does not speak Farsi. Resident 350 further stated that he has a hard time communicating with staff members because he does not speak English well and the staff does not speak Armenian. Resident 350 stated, I normally use sign language or gestures to make myself understood. Right now, I am soiled, and I need to be changed. However, I am not able to verbalize that I need to be changed. I have to wait for the staff to come and check on me.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 10/21/2024 at 10:16 a.m., inside Resident 350`s room, Registered Nurse 1 (RN1) present at Resident 350`s bedside stated that Resident 350 speaks Farsi. RN 1 stated Resident 350 does not have a communication device or board at his bedside. RN 1 stated the communication device or board would make it easier to communicate with the resident in his primary language. RN 1 stated the potential outcome of not providing a communication board to the residents who do not speak English is inability to communicate with the resident accurately and understand his needs. During a review of the facility's policy and procedure titled, Communication with Persons with Limited English Proficiency, reviewed 1/2024, the policy indicated that the facility will take responsible steps to ensure that persons with Limited English Proficiency (LEP) have meaning full access and an equal opportunity to participate in services, activities programs and other benefits. All interpreters, translators and other aids needed to comply with this policy shall be provided without cost to the person being served. The facility will promptly identify the language and communication needs of the LEP person. If necessary, staff will use a language identification card or posters to determine the language.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 38469 Based on observation, interview and record review, the facility`s Interdisciplinary Care Team (a group of professionals from different disciplines who work together to treat a patient's condition) failed to collaborate and communicate with the care team members the resident`s concern about her vision loss for one of one sampled resident (Resident 93). This deficient practice resulted in nurses` not being aware of the resident`s visual function status which has the potential for the resident to fall and suffer serious injury due to inability to see. Findings: During a review of Resident 93's Admission Record, the Admission Record indicated the facility admitted the resident on 8/26/2024 with diagnoses that included depression (characterized by a prolonged low mood and loss of interest in activities that used to be enjoyable) and chronic respiratory failure (shortness of breath or feeling like you can't get enough air, extreme tiredness, an inability to exercise as you did before, and sleepiness). During a review of Resident 93's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 9/01/2024, the MDS indicated the resident's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was intact and the resident was dependent on staff for toileting, shower, lower body dressing, and putting on and taking off footwear. During a concurrent interview and record review with Licensed Vocational Nurse 1 (LVN 1) on 10/23/24 at 11:29 a.m., Resident 93`s Social Services-Admission-Evaluation (SSAE) notes, which indicated that the resident was visually impaired, was reviewed. Upon assessment and confirmation by LVN1 of the resident`s visual functioning, at the resident`s bedside, the resident was unable to count how many of LVN 1`s fingers were in front of her face with 1 1/2 feet distance. The resident stated she cannot see the LVN`s hand and can only see the shadow of the LVN 1`s face. During an interview on 10/23/24 11:40 a.m., with Registered Nurse Supervisor (RN1), RN1 stated that they are not aware that the resident was visually impaired. RN1 stated that there was no communication from the Social Services staff that the resident is visually impaired. RN1 then went into the resident`s room and verified the sign posted above the resident`s bed that says, Visually Impaired. RN1 stated they could have care planned (a plan for an individual's specific health needs and desired health outcomes) the resident`s risk factors such as a potential for fall which can cause injury if not prevented. (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow up interview with LVN1 on 10/24/24 at 8:56 p.m., LVN1 stated that the Social Services staff that did the assessment should have discussed with the nurses` the resident`s complaint of visual impairment. LVN1 stated that there should have been a Change of Condition (COC) triggered to further assess the resident and identify the risks and care needs of a visually impaired resident. LVN1 stated that a Care Plan should have been initiated upon identification of the resident`s visual impairment and development of a goal of treatment and outline interventions to achieve the goals. LVN1 stated that without a care plan for visual impairment, the resident`s care needs would not be met and can result to the resident`s becoming depressed about her situation. During a concurrent interview and record review with the Social Services Director (SSD) on 10/24/24 at 10:09 a.m., Resident 93's Social Services-Admission Evaluation (SSAE) dated 9/2/2024 was reviewed. The SSD stated that in the section Psychosocial Evaluation, it indicated that the resident is visually impaired. The SSD stated that Resident 93 had told her that her vision is a little off. The SSD stated that she had informed the nurse about the resident`s vision problem but was unable to remember who was the nurse that she spoke to. Also reviewed with the SSD, the Resident 93`s Care Conference-Interdisciplinary, dated 9/3/2024. The SSD stated that she did not mention the resident`s complaint about her vision to the Interdisciplinary Team (a group of health care professionals with various areas of expertise who work together toward the goals of their clients), and nothing was discussed in this care conference the resident`s complaint about her vision problem. During a review of the facility`s policy on Interdisciplinary Team Guidelines, Care Planning, last reviewed on January 2024, the policy indicated that it is the policy of this facility to include appropriate members of the IDT in the care planning process to effectuate, as appropriate, person-centered care . During a review of the facility`s policy and procedure titled Blind Resident, Care Suggestions, last reviewed on January 2024, the policy indicated that It is the policy of this facility to provide care for the blind resident in accordance with individual needs, preferences, and plan of care .  During a review of the facility`s policy and procedures titled Fall/Accident Mitigation and Intervention, last reviewed in January 2024, the policy indicated that It is the policy of the facility to minimize the risk of serious injury associated with fall or accidents .

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38549 Based on interview and record review, the facility failed to ensure licensed nurses provided non-pharmacological interventions (any type of healthcare intervention which is not primarily based on medication) prior to administering as needed (prn) opioid pain medication (treats moderate to severe pain) to a resident for two of 30 sampled residents (Resident 204 and 26). This deficient practice had the potential to place the resident at increased risk of experiencing adverse side effects (undesired harmful effect resulting from a medication or other intervention). Findings: a. During a review of Resident 204's Admission Record, the Admission Record indicated the facility admitted the resident on 10/14/2024 with diagnoses including atrial fibrillation (a heart condition that causes an irregular heartbeat) and pneumonitis (inflammation of the lung tissue). During a review of Resident 204's History and Physical (H&P - a comprehensive assessment of a resident that includes taking a detailed medical history from the resident and then performing a physical examination to gather objective findings), dated 10/15/2024, the H&P indicated the resident had fluctuating (to change or vary) capacity to give informed consent (a process in which residents are given important information, including possible risks and benefits, about a medical procedure or treatment) regarding his medical/physical treatment relating to an existing and continuing medical condition. During a review of Resident 204's care plan (a document that outlines a resident's health care needs and goals, and the treatments and activities that will help the resident achieve them) for chronic (persisting for a long time or constantly recurring) pain, initiated on 10/15/2024, the care plan indicated to offer/provide non-pharmacological pain relieving remedies (e.g. positioning, relaxation therapy, diversion/distraction, bathing, heat and cold application). During a review of Resident 204's physician's orders, the physician's orders indicated the following: - Hydrocodone-acetaminophen (medication used to treat moderate to severe pain) 10-325 milligrams (mg - unit of measurement), give one tablet by mouth every eight (8) hours as needed for moderate to severe pain 4-10/10 (numerical scale used to measure pain with 0 being no pain and 10 being the worst pain), ordered on 10/15/2024 and discontinued on 10/21/2024. - Hydrocodone-acetaminophen 5-325 mg, give one tablet by mouth every 8 hours as needed for moderate to severe pain 4-6/7-10/10, ordered on 10/21/2024. During a concurrent interview and record review on 10/24/2024 at 8:10 a.m., with Licensed Vocational Nurse 1 (LVN 1), reviewed Resident 204's Medication Administration Record (MAR - a report that serves as a legal record of the drugs administered to a resident at a facility by a health care professional) dated 10/2024. LVN 1 verified by stating the following: (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Hydrocodone-acetaminophen 10-325 mg was administered on 10/15/2024 at 3 p.m., and no non-pharmacological interventions were documented as being attempted. - Hydrocodone-acetaminophen 10-325 mg was administered on 10/16/2024 at 4:30 p.m., and no non-pharmacological interventions were documented as being attempted. - Hydrocodone-acetaminophen 10-325 mg was administered on 10/17/2024 at 9:52 a.m. and 6:46 p.m., and no non-pharmacological interventions were documented as being attempted. - Hydrocodone-acetaminophen 10-325 mg was administered on 10/18/2024 at 2:50 a.m., and no non-pharmacological interventions were documented as being attempted. - Hydrocodone-acetaminophen 10-325 mg was administered on 10/20/2024 at 4:29 p.m., and no non-pharmacological interventions were documented as being attempted. - Hydrocodone-acetaminophen 10-325 mg was administered on 10/21/2024 at 9:05 a.m., and no non-pharmacological interventions were documented as being attempted. - Hydrocodone-acetaminophen 5-325 mg was administered on 10/22/2024 at 8:30 a.m., and no non-pharmacological interventions were documented as being attempted. LVN 1 stated it was important to first attempt non-pharmacological interventions prior to administering an opioid pain medication to ensure that it was not being given unnecessarily. LVN 1 stated that residents could experience adverse side effects such as increased drowsiness, nausea/vomiting, and constipation, especially since they are taking so many other medications. LVN 1 stated that, sometimes, residents' pain can be alleviated through non-pharmacological interventions, and medication may not even be necessary. During an interview on 10/24/2024 at 10:26 a.m., with the Director of Nursing (DON), the DON stated it was good nursing practice to attempt non-pharmacological interventions prior to administering opioid pain medication because residents can experience side effects such as sleepiness, constipation, and central nervous system (CNS - made up of the brain and spinal cord) depression with the use of opioid pain medications. During a review of the facility's policy and procedure titled, Pain Assessment, last reviewed and revised on 1/17/2024, the policy and procedure indicated that the effectiveness of any intervention, i.e. mediation, positioning, distraction, etc., shall be documented. 44309 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056092	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Topanga Terrace	22125 Roscoe Blvd Canoga Park, CA 91304

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F 0697

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

b. During a review of Resident 26's Admission Record, the document indicated that the facility originally admitted the resident on 7/11/2024, and readmitted on [DATE], with diagnoses including chronic respiratory failure (a long-term condition in which the respiratory system is unable to adequately exchange oxygen to the body), dependence on respirator (ventilator - a mechanical device that helps you breathe by moving air in and out of your lungs), encounter for attention to gastrostomy (G-tube-a surgical procedure used to insert a tube through the abdomen and into the stomach and used to provide a route for tube feeding), encounter for attention to tracheostomy (a surgical procedure that creates an opening in the neck into the windpipe [trachea] to insert a tube that helps with breathing), and pain in leg.

During a review of Resident 26's Minimum Data Set (MDS - a standardized assessment and screening tool) dated 10/15/2024, the document indicated the resident`s cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was intact (decisions consistent/reasonable).

During a review of Resident 26`s Physician orders dated 9/1/2024, the document indicated to document non-pharmacological interventions attempted for the resident`s pain and the effectiveness prior to the administration of PRN (as needed) pain medication as follows: 1-heat, 2-cold, 3-positioning, 4-massage, 5-music/television, 6-gentle Range of Motion (ROM- how far you can move or stretch a part of your body), 7-diversional activity (is the act of switching your focus onto something else), 8- quiet environment, 9- other (chart on progress notes), 10-refused.

During a review of Resident 26's Physician orders dated 9/1/2024, the document indicated that Resident 26 had an order for Hydrocodone-Acetaminophen oral tablet (used to treat moderate to severe pain) 5-325 mg, to administer one tablet via G-tube every six hours as needed for moderate to severe pain (4-10/ pain rating scale of zero being no pain and 10 being the worst pain possible).

During a review of Resident 26`s Care Plan dated 7/11/2023, the document indicated that the resident had actual pain related to chronic respiratory failure with hypoxia (low levels of oxygen in your body tissues), tracheostomy, gastrostomy, and reduced mobility. The care plan interventions indicated to offer/provide non-pharmacological pain-relieving remedies (e.g. positioning, relaxation therapy, diversion/distraction), to observe/record/report to the nurse of the physician any sign and symptoms of non-verbal pain and to evaluate the effectiveness of pain interventions.

During a review of Resident 26's MAR for the month of 9/2024, the document indicated the resident received hydrocodone-acetaminophen tablets two times on 9/2/2024 and 9/5/2024, three times on 9/8/2024, 9/9/2024, 9/10/2024, 9/12/2024, 9/15/2024, and four times on 9/11/2024. Resident 26 did not receive any non-pharmacological interventions prior to receiving PRN pain medication.

During a review of Resident 26's MAR for the month of 10/2024, the document indicated the resident received hydrocodone-acetaminophen tablets four times on 10/4/2024, five times on 10/5/2024, two times on 10/11/2024, and three times on 10/18/2024, and 10/19/2024. Resident 26 did not receive any non-pharmacological interventions prior to receiving PRN pain medication.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056092	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER Topanga Terrace		STREET ADDRESS, CITY, STATE, ZIP CODE 22125 Roscoe Blvd Canoga Park, CA 91304	

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 10/23/2023 at 3:04 p.m., with the Director of Nursing (DON), reviewed Resident 26`s MARs dated 9/2024 and 10/2024 and physician orders. The DON stated licensed nurses are required to perform non-pharmacological pain interventions before administering any as needed pain medications. The DON stated Resident 26 received hydrocodone-acetaminophen tablet for pain four times on 10/4/2024, five times on 10/5/2024, two times on 10/11/2024, and three times on 10/18/2024 and 10/19/2024. The DON stated the licensed staff did not offer any non-drug methods to reduce Resident 26`s pain as ordered by the physician prior to administering PRN pain medication. The DON further stated Resident 26 received hydrocodone-acetaminophen tablets two times on 9/2/2024 and 9/5/2024, three times on 9/8/2024, 9/9/2024, 9/10/2024, 9/12/2024, 9/15/2024, and four times on 9/11/2024. The DON stated licensed staff did not provide non-pharmacological interventions prior to administering PRN pain medication. The DON stated the potential outcome is unrelieved pain and discomfort. During a review of the facility`s policy and procedures titled Pain Assessment, reviewed January 2024, the policy indicated it is the policy of this facility to assess residents for pain and provide adequate pain management as indicated. The plan of care may include non-pharmacological interventions which may include, but not limited to, repositioning, dimming lights, quit environment, application of hot or cold packs, relaxation techniques, distraction/activities, music, massage and /or any other individualized approaches. The effectiveness of any interventions , i.e. medication, positioning, distraction, etc., shall be documented.

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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. 38549 Based on interview and record review, the facility failed to ensure that two of 30 sampled residents (Residents 24 and 70) were administered medications as prescribed by the physician when: 1. Lorazepam (anti-anxiety medication) was not administered to Resident 24 in accordance with physician's orders. 2. Three doses of metoprolol (a medication that treats high blood pressure, chest pain, and heart failure) were not held as ordered when Resident 70 received dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed). These deficient practices had the potential to place Resident 24 at increased risk of being given extra doses of lorazepam and Resident 70 to experience low blood pressure. Findings: 1. During a review of Resident 24's Admission Record, the Admission Record indicated the facility admitted the resident on 8/16/2024 with diagnoses including acute and chronic respiratory failure (inadequate gas exchange by the respiratory system). During a review of Resident 24's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 10/7/2024, the MDS indicated the resident had severely impaired cognition (the mental process of acquiring knowledge and understanding through the senses, experience, and thought) and was dependent on staff for activities of daily living (ADLs - the basic tasks people need to do every day to care for themselves and stay safe and healthy). On 10/24/2024 at 8:22 a.m., a concurrent interview and record review of Resident 24's physician's orders were conducted with Licensed Vocational Nurse 1 (LVN 1). LVN 1 stated the resident had an order for lorazepam 0.5 milligrams (mg - unit of measurement) via gastrostomy tube (GT - a surgically inserted tube that provides direct access to the stomach for nutritional support, hydration, and medication) as needed (prn) for anxiety manifested by inability to stay still and pulling out tubes for 30 days at midnight. Reviewed the resident's 10/20204 Medication Administration Record (MAR - a report that serves as a legal record of the drugs administered to a patient at a facility by a health care professional) with LVN 1. LVN 1 stated lorazepam 0.5 mg prn was given to the resident on the following dates and times: 1. 10/4/2024 at 8 a.m. 2. 10/5/2024 at 3:36 p.m. 3. 10/7/2024 at 2:44 p.m. 4. 10/9/2024 at 5:17 p.m. (continued on next page)

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F 0755

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

5. 10/10/2024 at 3:16 p.m.

6. 10/14/2024 at 11:45 a.m.

7. 10/18/2024 at 4:32 p.m.

8. 10/19/2024 at 9:38 a.m.

LVN 1 stated lorazepam was ordered to be given at midnight because that was usually the time when the resident became increasingly agitated. LVN 1 stated the nurses should have been administering the lorazepam at midnight. LVN 1 stated if the nurses needed to administer the lorazepam at any other time than midnight, then they should have called to inform the doctor first. LVN 1 stated she could not find any documentation indicating that the doctor was notified that the resident needed lorazepam at other times besides midnight.

During a review of Resident 24's care plan (a document that outlines a patient's health care needs and goals, and the treatments and activities that will help the patient achieve them) for behavior of anxiety manifested by inability to stay still leading to pulling out tubing, initiated on 8/30/2024, the care plan indicated to administer anti-anxiety medication as ordered.

On 10/24/2024 at 9:57 a.m., during an interview, the Director of Nursing (DON) stated the licensed nurses should have informed the doctor that the resident was manifesting behaviors and needed lorazepam at other times than midnight. When asked if the nurses were following the physician's orders, the DON stated, No.

During a review of the facility's policy and procedure titled, Medication Administration - General Guidelines, last reviewed and revised on 1/17/2024, the policy and procedure indicated that medications are administered as prescribed in accordance with good nursing principles and practices .The five rights - right resident, right drug, right dose, right route, and right time are applied for each medication being administered . Medications are administered in accordance with written orders of the prescriber.

50033

2. During a review of Resident 70's Admission Record, the Admission Record indicated the facility originally admitted the resident on 11/23/2022 and readmitted the resident on 9/12/2024 with diagnoses including, but not limited to, ESRD (ESRD - irreversible kidney failure), acute (when symptoms begin and worsen quickly) and chronic (long-term) respiratory failure with hypoxia (when your blood doesn't carry enough oxygen to your tissues), and metabolic encephalopathy (the loss of brain function due to a chemical imbalance in the blood).

During a review of Resident 70's History and Physical, dated 9/19/2024, the History and Physical indicated Resident 70 could make his needs known but could not make medical decisions.

During a review of Resident 70's Order Summary Report, the Order Summary Report indicated the following active orders:

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Bedside hemodialysis to be performed by Dialysis Company (DC) 1 every Monday, Wednesday, and Friday. 2. Give one metoprolol 50 milligram tablet every eight hours for hypertension (high blood pressure). Hold the dose at 2:00 p.m. on dialysis days (Monday, Wednesday, and Friday). During a concurrent interview and record review on 10/24/2024 with Licensed Vocational Nurse (LVN) 2, Resident 70's medication administration record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated October 2024, indicated metoprolol was administered to Resident 70 at 2:00 p.m. on Monday 10/7/2024, Wednesday 10/16/2024, and Monday 10/21/2024. LVN 2 stated the metoprolol should have been held on those shifts. LVN 2 stated Resident 70's blood pressure could be low if he is given metoprolol at those times. During a review of Resident 70's dialysis assessments, dated 10/7/2024, 10/16/2024, and 10/24/2024, the dialysis assessments indicated Resident 70 received dialysis on these dates. During a current interview and record review on 10/24/2024 at 3:26 p.m. with the Director of Nursing (DON), DON confirmed Resident 70's MAR, dated October 2024, indicated metoprolol was administered to Resident 70 at 2:00 p.m. on 10/7/2024, 10/16/2024, and 10/21/2024. The DON stated the metoprolol should have been held at those times, and the resident could experience hypotension (low blood pressure) if it is not held. During a review of the facility's policy and procedure titled, Dialysis Resident, Care Of, last reviewed 1/17/2024, the policy and procedure indicated medications on days of dialysis should only be held by physician's order. During a review of the facility's policy and procedure titled, Medication Administration - General Guidelines, last reviewed 1/17/2024, the policy and procedure indicated medications are administered in accordance with written orders of the prescriber. The policy and procedure further indicated the physician's orders should be checked for the correct dosage schedule before administration of any medication.

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F 0758

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.

38549

Based on interview and record review, the facility failed to ensure licensed nurses attempted non-pharmacological interventions (any type of healthcare intervention which is not primarily based on medication) prior to administering as needed (prn) lorazepam (medication used to treat anxiety disorder [intense, excessive, and persistent worry and fear about everyday situations]) to a resident for one of 30 sampled residents (Resident 24).

This deficient practice had the potential to place the resident at increased risk of experiencing adverse side effects (undesired harmful effect resulting from a medication or other intervention) from lorazepam.

Findings:

During a review of Resident 24's Admission Record, the Admission Record indicated the facility admitted the resident on 8/16/2024 with diagnoses including acute (sudden) and chronic (persisting for a long time or constantly recurring) respiratory failure (inadequate gas exchange by the respiratory system).

During a review of Resident 24's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 10/7/2024, the MDS indicated the resident had severely impaired cognition (the mental process of acquiring knowledge and understanding through the senses, experience, and thought) and was dependent on staff for activities of daily living (ADLs - activities related to personal care).

During a review of Resident 24's care plan (a document that outlines a resident's health care needs and goals, and the treatments and activities that will help the resident achieve them) for behavior of anxiety manifested by inability to stay still leading to pulling out tubing (medical device), initiated on 8/30/2024, the care plan indicated to provide non-pharmacological interventions to alleviate anxiety: reposition for comfort, reposition GT tubing as needed, deep breathing exercises, relaxation therapy, diversion/distraction, music therapy, and storytelling.

During a concurrent interview and record review on 10/24/2024 at 8:22 a.m., with Licensed Vocational Nurse 1 (LVN 1), reviewed Resident 24's physician's orders and Medication Administration Record (MAR - a report that serves as a legal record of the drugs administered to a resident at a facility by a health care professional). LVN 1 stated Resident 24 had an order for lorazepam 0.5 milligrams (mg - unit of measurement) via gastrostomy tube (GT - a surgically inserted tube that provides direct access to the stomach for nutritional support, hydration, and medication) as needed for anxiety manifested by inability to stay still and pulling out tubes for 30 days at midnight, ordered 9/20/2024. LVN 1 verified by stating the following:

- On 10/4/2024 at 8 a.m., the nurse administered lorazepam to Resident 24 but did not document that non-pharmacological interventions were attempted first.

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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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 10/5/2024 at 3:36 p.m., the nurse administered lorazepam to Resident 24 but did not document that non-pharmacological interventions were attempted first. - On 10/7/2024 at 2:44 p.m., the nurse administered lorazepam to Resident 24 but did not document that non-pharmacological interventions were attempted first. - On 10/9/2024 at 5:17 p.m., the nurse administered lorazepam to Resident 24 but did not document that non-pharmacological interventions were attempted first. - On 10/10/2024 at 3:16 p.m., the nurse administered lorazepam to Resident 24 but did not document that non-pharmacological interventions were attempted first. - On 10/14/2024 at 11:45 a.m., the nurse administered lorazepam to Resident 24 but did not document that non-pharmacological interventions were attempted first. - On 10/16/2024 at 12 a.m., the nurse administered lorazepam to Resident 24 but did not document that non-pharmacological interventions were attempted first. - On 10/18/2024 at 4:32 p.m., the nurse administered lorazepam to Resident 24 but did not document that non-pharmacological interventions were attempted first. - On 10/19/2024 at 12:26 a.m. and 9:38 a.m., the nurse administered lorazepam to Resident 24 but did not document that non-pharmacological interventions were attempted first. LVN 1 stated it was important to first attempt non-pharmacological interventions prior to administering lorazepam to ensure that it was not being given unnecessarily. LVN 1 stated that residents could experience adverse side effects such as increased drowsiness. LVN 1 stated that medication may not even be necessary if non-pharmacological interventions can alleviate the resident's symptoms. During an interview on 10/24/2024 at 9:57 a.m., with the Director of Nursing (DON), the DON stated it was good nursing practice for nurses to attempt non-pharmacological interventions prior to administering medication because residents can experience adverse side effects, such as sedation (state of relaxation or sleepiness caused by drugs), from lorazepam. During a review of the facility's policy and procedure titled, Psychoactive Medications (a drug or other substance that affects how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior), last reviewed and revised on 1/17/2024, the policy and procedure did not indicate any information regarding non-pharmacological interventions. During an interview on 10/24/2024 at 10:26 a.m., with the DON, the DON stated that was the only policy and procedure the facility had regarding the use of psychoactive medications.

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38469 Based on interview and record review, the facility failed to ensure one of two sampled residents Resident 65 was free from significant medication error by failing to ensure metoprolol (medication to treat high blood pressure [the force of the blood pushing on the blood vessel walls is too high]) was administered in accordance with the physician's order with parameter to hold (do not give) the medication if Resident 65's heart rate is less than 60 beats per minute (bpm-a normal resting heart rate for adults ranges from 60 to 100 beats per minute). This deficient practice placed Resident 65 at risk for bradycardia (low heart rate- can be life threatening if the heart is unable to maintain a rate that pumps enough oxygen-rich blood throughout the bod) which could lead to shortness of breath, chest pain, fatigues, and dizziness. Findings: During a review of Resident 65's Admission Record, the Admission Record indicated the facility originally admitted the resident on 6/11/2021 and readmitted on [DATE], with diagnoses including type 2 diabetes mellitus and traumatic brain injury (a brain injury caused by an external force, such as a blow to the head or a sharp object piercing the brain), and hypertensive chronic disease (a common condition that occurs when blood pressure is consistently too high over time). During a review of Resident 65's Minimum Data Set (MDS-standardized assessment and screening tool) dated 7/26/2024, the MDS indicated resident was comatose (a deep state of unconsciousness where a person cannot be awakened or respond to stimuli). During a review of Resident 65's physician order dated 9/24/2024, the document indicated resident had an order for Metoprolol tartrate 25 mg, give one tablet by mouth two times a day for hypertension, hold for heart rate less than 60 bpm. During a concurrent interview and record review on 10/23/2024 at 9:40 a.m., with Licensed Vocational Nurse 1 (LVN1), Resident 65's Medication Administration Record (MAR-includes key information about the individual's medication including, the medication name, dose taken, special instructions and date and time) for the month of October 2024 was reviewed. LVN 1 stated that on 10/19/2024 at 9:00 a.m., Resident 65`s heart was 50 bpm and at 5:00 p.m. the resident`s heart rate was 59 bpm. LVN 1 stated that on this date, Metoprolol were administered despite the physician`s order to hold if the heart rate is below 60 beats per minute as documented in the MAR. LVN1 stated that the administration of Metoprolol could have caused the resident`s heart rate to drop some more which could lead to dizziness, headache, and life-threatening complications of bradycardia. During a review of the facility`s policy on Medication Administration-General Guidelines, last reviewed on 1/17/2024, the policy indicated that Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so .

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38469 Based on observation, interview, and record review, the facility failed to ensure leftover food brought from outside was stored in the refrigerator or discarded per facility policy for one of one sampled resident (Resident 43) investigated under Food Safety Requirement. This deficient practice had the potential to result in foodborne illness (also called food poisoning, illness caused by eating contaminated food) for Resident 43. Findings: During a review of Resident 43's Admission Record, the document indicated the resident was originally admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses that included depression (a serious mood disorder that can affect a person's thoughts, feelings, behavior, and sense of well-being) and type 2 diabetes mellitus (a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel). During a review of Resident 43`s Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 10/04/2024, the MDS indicated the resident`s cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was intact. The MDS also indicated that the resident was totally dependent on staff for activities of daily living (ADL- are activities related to personal care. They include bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating). During a concurrent observation and interview on 10/21/2024 at 9:33 a.m., with Certified Nursing Assistant 1 (CNA 1), in Resident 43`s room, observed an overbed table with a clear cup containing a yellow flan and a container of an unknown nutriment (food) on top. CNA 1 stated that the content of the cup was a flan, and the other container was a partially eaten enchilada (a Mexican dish consisting of a corn tortilla rolled around a filling and covered with a savory sauce). CNA 1 stated that these were brought by the family the day before. During an interview on 10/21/2024 at 9:45 a.m., and while in the hallway across Resident 43`s room, Registered Nurse 2 (RN2) went to the resident`s room and confirmed that the cup containing a flan and the container of enchilada belonged to Resident 43. RN2 stated that leftover food had to be refrigerated and discarded after 24 hours. RN2 stated she could not tell when these food items were in the resident's room since it had no label. RN2 stated the food in those two containers were not safe for the resident to consume and that it may cause foodborne illnesses. During a review of the facility`s policy and procedure titled, Food for Residents From Outside Sources, last reviewed on 1/17/2024, the policy indicated that prepared food brought in for the resident must be consumed within one (1) hour of receiving it in an effort to prevent food borne illness. Unused food will be disposed of immediately thereafter.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056092	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER: Topanga Terrace		STREET ADDRESS, CITY, STATE, ZIP CODE: 22125 Roscoe Blvd Canoga Park, CA 91304	

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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. 38549 Based on observation, interview, and record review, the facility failed to: 1. Ensure Licensed Vocational Nurse 3 (LVN 3) donned (put on) a gown prior to administering medications to a resident via gastrostomy tube (GT - a small tube that is surgically inserted into the stomach through the abdomen to provide nutrition, fluids, and medication) who was on enhanced barrier precautions (EBP - a set of infection control practices that use personal protective equipment [PPE - equipment worn to reduce exposure to hazards in the workplace] to reduce the spread of multidrug-resistant organisms [MDROs - bacteria that are resistant to three or more classes of antimicrobial drugs] in nursing homes) for one of 30 sampled residents (Resident 77). 2. Ensure a resident's nasal cannula (device used to deliver supplemental oxygen placed directly on a resident's nostrils) oxygen tubing was kept off the floor for one of 30 sampled residents (Resident 204). These deficient practices placed the residents at increased risk of developing an infection. Findings: 1. During a review of Resident 77's Admission Record, the Admission Record indicated the facility originally admitted the resident on 1/16/2023 and readmitted the resident on 10/8/2024 with diagnoses including chronic respiratory failure (a long-term condition in which the respiratory system is unable to adequately exchange oxygen to the body), encounter for attention to tracheostomy (a surgical procedure that creates an opening in the neck into the windpipe [trachea] to insert a tube that helps with breathing), dependence on respirator (ventilator - a mechanical device that helps you breathe by moving air in and out of your lungs) status, and encounter for attention to gastrostomy (a surgical procedure that creates an opening in the abdomen and inserts a tube into the stomach). During a review of Resident 77's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 7/18/2024, the MDS indicated the resident had severely impaired cognition (the mental process of acquiring and using knowledge through the senses, experience, and thought) and was dependent on staff for activities of daily living (ADLs - activities related to personal care). During a review of Resident 77's care plan (a document that outlines a resident's health care needs and priorities, and the treatments and care services that will be provided to address them), initiated on 9/18/2024, the care plan indicated Resident 77 required EBP. Among some of the interventions listed included to wash hands or perform hand hygiene and don appropriate PPE prior to performing high-contact tasks. During a medication administration observation on 10/22/2024 at 8:17 a.m., observed LVN 3 prepare medications for Resident 77. Observed a sign outside Resident 77's room indicating the residents inside were on EBP. Observed LVN 3 administer medications to Resident 77 via GT without first donning a gown. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/22/2024 at 9:36 a.m., with LVN 3, when asked what the process was for administering medications via GT to a resident on EBP, LVN 3 stated she should have worn a gown but forgot to put one on. During an interview on 10/24/2024 at 9:16 a.m., with the Infection Preventionist (IP), the IP stated that residents with a GT are placed on EBP. The IP stated nurses should don a gown when performing high contact activities for residents on EBP, such as dressing, bathing, providing hygiene care, and giving medications through the GT, in order to prevent the spread of infection. During an interview on 10/24/2024 at 9:57 a.m., with the Director of Nursing (DON), the DON stated that nurses should wear a gown when giving medications to a resident on EBP for infection control. During a review of the facility's policy and procedure titled, Enhanced Barrier Precautions, last reviewed and revised on 1/17/2024, the policy indicated that EBP expands the use of PPE and refers to the use of gowns and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities. The use of gown and gloves for high-contact resident care activities is indicated, when Contact Precautions (used when a resident has an infectious disease that may be spread by touching either the resident or other objects the resident has handled) do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices (a device that is left inside the body) regardless of MDRO colonization (when a microorganism [organism that can only been seen with a microscope] is present in or on a host but it doesn't cause disease or symptoms) as well as for residents with MDRO infection or colonization. 2. During a review of Resident 204's Admission Record, the Admission Record indicated the facility admitted the resident on 10/14/2024 with diagnoses including atrial fibrillation (a heart condition that causes an irregular heartbeat) and pneumonitis (inflammation of the lung tissue). During a review of Resident 204's History and Physical (H&P - a comprehensive assessment of a resident that includes taking a detailed medical history from the resident and then performing a physical examination to gather objective findings), dated 10/15/2024, the H&P indicated the resident had fluctuating (to change or vary) capacity to give informed consent (a process in which residents are given important information, including possible risks and benefits, about a medical procedure or treatment) regarding his medical/physical treatment relating to an existing and continuing medical condition. During a concurrent observation and interview on 10/21/2024 at 10:02 a.m., with Licensed Vocational Nurse 4 (LVN 4), observed Resident 204 awake in bed and wearing an oxygen nasal cannula. Observed the nasal cannula oxygen tubing on the floor. LVN 4 verified by stating that the oxygen tubing was on the floor and stated she would get a new one. During an interview on 10/24/2024 at 9:55 a.m., with the Director of Nursing (DON), the DON stated residents' oxygen tubing should be kept off the floor for infection control. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure titled, Precautions - Standard, last reviewed and revised on 1/17/2024, the policy indicated it is the policy of the facility to utilize standard precautions when caring for patients/residents regardless of their diagnoses, or suspected or confirmed infection status. Standard precautions presume that all blood, body fluids, secretions, and excretions (except sweat), non-intact skin and mucous membranes may contain transmissible infectious agents. During an interview on 10/24/2024 at 10:27 a.m., with the DON, the DON stated the policy and procedure titled, Precautions - Standard, was the only policy and procedure she could find regarding the issue of keeping oxygen tubing off the floor.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 44309 Based on interview and record review, the facility failed to implement its policies and procedures related to the influenza (a high contagious viral infection of the respiratory passages) vaccine for one of five sampled residents (Resident 93). This deficient practice placed Resident 93 at an increased risk of acquiring (to get) and transmitting (pass on) the influenza virus to other residents in the facility. Findings: During a review of Resident 93`s Admission Record, the Admission Record indicated the facility admitted the resident on 8/26/2024, with diagnoses including encephalopathy (a change in your brain function due to injury or disease), abnormal posture (when the position of the body is not normal), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with your daily activities of living). During a review of Resident 93's Minimum Data Set (MDS - a comprehensive assessment and care screening tool) dated 9/1/2024, the MDS indicated that the resident`s cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was intact (decisions consistent/reasonable). The MDS indicated that Resident 93 was dependent on staff (helper does all the effort) for toileting hygiene, showering and bathing, and lower body dressing. The MDS further indicated that Resident 93 was not in the facility during this year`s influenza vaccination season.  During a review of Resident 93`s History and Physical (H&P) dated 9/3/2024, the H&P indicated that the resident was not competent (having the necessary ability or knowledge) to enter into a contract, including an admission agreement. During a review of Resident 93`s Immunization Report, the report indicated that the resident received the influenza vaccine on 9/11/2024. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 10/24/2024 at 11:00 a.m., with the facility`s Infection Preventionist Nurse (IP), Resident 93`s vaccination records, Medication Administration Record (MAR) and informed consents (the process in which a health care provider educates a patient about the risks, benefits, and alternatives of a given procedure or intervention) for vaccinations were reviewed. The IP stated Resident 93 received her influenza vaccine on 9/11/2024, based on the Immunization Record. However, during a record review of Resident 93`s MAR for September 2024, the IP stated that Resident 93 did not receive her influenza vaccine on 9/11/2024. The IP stated when licensed staff administer the influenza vaccine to the residents, they documented in the MAR and this documentation was missing for Resident 93 on 9/11/2024. The IP further stated there was no informed consent obtained from Resident 93 or her Responsible Party (RP) regarding administration of the influenza vaccine. The IP stated licensed staff are required to speak with the residents or their RPs upon admission to see if they would like to receive the influenza vaccine. The IP stated, Seems like I did not check with Resident 93 or her RP to see if they were interested to receive the influenza vaccine. I documented by mistake that Resident 93 received her influenza vaccine on 9/11/2024. The IP stated the potential outcome of not offering a resident the influenza vaccine is the increased risk of getting the infection. During an interview on 10/24/2024 at 2:05 p.m., with the Director of Nursing (DON), the DON stated licensed staff are required to offer the Influenza vaccination to all residents upon admission. The DON stated Resident 93 did not receive the influenza vaccine since her admission to the facility. The DON stated the IP documented that she administered the influenza vaccine to Resident 93 on 9/11/2024 by mistake. The DON stated the potential outcome of not offering the influenza vaccine to a resident is placing them at the risk of contracting the virus and getting sick. During a review of the facility's policy and procedure titled Influenza and Pneumococcal Vaccine (helps protect against bacteria that cause lung inflammation) Administration, reviewed January 2024, the policy indicated that the resident or responsible party will be given the information to make a decision regarding the administration of the pneumococcal or flu vaccinations during the admission process. The facility may post that the flu vaccine will be administered beginning on a specific date and shall be part of consent for treatment. Promptly after administering the vaccinations, chart on MAR in accordance with the policy and procedures regarding medication administration noting the site and lot number of the vaccinations administered.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44309 Based on interview and record review, the facility failed to offer the Coronavirus Disease (COVID-19, a severe respiratory illness caused by virus and transmitted from person to person) vaccination to one of five sampled residents (Resident 43). This deficient practice placed Resident 43 at a higher risk of acquiring (to get) and transmitting (pass on) the COVID-19 virus to other residents in the facility. Findings: During a review of Resident 43`s Admission Record, the Admission Record indicated that the facility originally admitted the resident on 2/3/2017, and readmitted on [DATE], with diagnoses including chronic respiratory failure (a condition in which your lungs have a hard time loading your blood with oxygen or removing carbon dioxide), encounter for attention to tracheostomy (an opening created at the front of the neck so a tube can be inserted into the windpipe [trachea] to help you breathe), and dependence on respirator (cannot breathe without a machine). During a review of Resident 43's Minimum Data Set (MDS - a comprehensive assessment and care screening tool) dated 7/6/2024, the MDS indicated the resident`s cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was intact (decisions consistent/reasonable). The MDS indicated that Resident 43 was dependent on staff (helper does all the effort) for toileting hygiene, showering and bathing, eating, and personal hygiene. During a review of Resident 43's Immunization Report, the report indicated that Resident 43 received the COVID-19 Pfizer (name of a company) Comirnaty Booster vaccine (an additional vaccine dose given to individuals) on 11/21/2023. During a review of Resident 43`s Nursing Progress Notes dated 11/17/2023 at 5:16 p.m., the document indicated that the facility`s licensed staff obtained a verbal consent for administration of the COVID-19 vaccine via telephone from Resident 43`s family member.  During a review of Resident 43`s Medication Administration Record (MAR- includes key information about the individual's medication including, the medication name, dose taken, special instructions and date and time) for November 2023, the document indicated that a licensed nurse had marked other-see progress notes-9 for the administration of the COVID-19 Pfizer Comirnaty Booster vaccine. During a review of Resident 43`s Nursing Progress Notes dated 11/21/2023 at 11:47 p.m., the document indicated, Vaccine given by previous nurse, please see immunization record.  During a review of Resident 43`s Care Plans, the document indicated no care plan was initiated to monitor potential adverse effects (a negative or harmful result) of administration of updated COVID-19 vaccine. (continued on next page)

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	056092	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 10/24/2024 at 11:35 a.m., with the facility`s Infection Preventionist Nurse (IP), Resident 43`s Immunizations Record, MAR and Nursing Progress Notes were reviewed. The IP stated Based on Resident 43`s Immunization Record, it looks like I administered the COVID-19 vaccine to the resident on 11/21/2023. However, on the Resident 43`s MAR for November 2023, my name is not indicated as a person who administered the vaccine. A licensed nurse had mentioned that this vaccine was administered by someone else. I do not remember if I administered this vaccine to Resident 43 and If I was the one, I don't understand why I did not document in the MAR myself. During a concurrent interview and record review on 10/24/24 at 1:08 p.m., with the facility`s Director of Nursing (DON), Resident 43`s Immunizations Record, MAR, and Nursing Progress Notes were reviewed. The DON stated Based on Resident 43`s Immunization records, it seems like the IP administered the COVID-19 vaccine on 11/21/2023. However, I do not know what time the COVID-19 vaccine was given to Resident 43. Resident 43`s Progress notes dated 11/21/2023, indicated that COVID-19 vaccine was given by a different nurse than the IP. The progress note does not say who the other nurse was. Why would a nurse document doing something that they did not do. The DON stated, I do not know if the COVID-19 vaccine was actually administered to Resident 43 on 11/21/2023. I would say the vaccine was not given to Resident 43 on 11/21/2023. During a telephone interview on 10/24/2024 at 1:30 p.m., with Resident 43`s Responsible Party 1 (RP1), the RP1 stated that the facility staff called him to get permission to administer the COVID-19 vaccine last year. However, the RP 1 stated that he is not sure whether or not Resident 43 received the COVID-19 vaccine. During a concurrent interview and record review on 10/24/2024 at 1:35 p.m., with the IP, Resident 43`s Care plans were reviewed. The IP stated no person-centered care plan was initiated for Resident 43 after the administration of the COVID-19 vaccine on 11/21/2023. The IP stated After the administration of the COVID-19 vaccine, I normally develop a care plan to monitor the resident post vaccine administration to see if the resident has any adverse reactions to the vaccine. I did not initiate a care plan with goal and interventions for Resident 43 post COVID-19 vaccine administration. It seems like the vaccine was never given to Resident 43. The IP stated the potential outcome of not administering the COVID-19 vaccine to an eligible resident increased the risk for the resident to contract COVID-19 and get sick. During a review of the facility's policy and procedure titled, COVID-19 Vaccination of Staff and Residents, reviewed January 2024, the policy indicated that if the purpose of this policy is to establish a process to encourage residents and staff to obtain the COVID-19 vaccine. If the resident is unvaccinated, the facility will make an effort to get them vaccinated within a week of admission.