

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056092	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/20/2025
NAME OF PROVIDER OR SUPPLIER Topanga Terrace		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to dispose garbage and refuse properly when there were soiled gloves on the floor in the dumpster (a movable waste container designed to be brought and taken away by a special collection vehicle, or to a bin that a specially designed garbage truck lifts) floor area. This failure had potential to attract birds, flies, insects, pests and possibly spread infection to 99 of 99 facility residents. Findings: During a concurrent observation and interview on 11/18/2025 at 11:00 a.m. of the dumpster with the Dietary Supervisor (DS), observed six (6) soiled gloves on the floor. The DS stated it was everyone's responsibility to maintain the cleanliness of the dumpster area to prevent attracting flies, rats and other pests because they do not want the pest in the facility as they are dirty and could get residents sick and pest could spread infection. The DS stated that it was not acceptable for the soiled gloves to be on the floor. During an interview on 11/18/2025 at 11:07 a.m. with the Housekeeping Director (HKD) at the dumpster area, the HKD stated they clean the trash every morning and detail clean it every Thursday using a power washer. The HKD stated the gloves on the floor were not acceptable as it could attract rats that could bring infections to the residents as a potential outcome. During a review of the facility's policies and procedures (P&P) titled Miscellaneous Area dated 1/15/2025, the P&P indicated The trash collection area is a potential feeding ground for vermin and rodents and must be kept clean. (1) The area must be swept and washed down by maintenance with a detergent on a regular basis. If a commercial rubbish service is used, arrangements must be made for periodic exchange of trash bins. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 5-501.116 Cleaning Receptacles. Proper storage and disposal of garbage and refused are necessary to minimize the development of odors, prevent such waste from becoming an attractant and harborage of breeding place for insects and rodents, and prevent the soiling of food preparation and food service areas. Improperly handled garbage creates nuisance conditions, makes housekeeping difficult, and may be possible source of contamination of food, equipment, and utensils. Outside receptacles must be constructed with tight-fitting lids or covers to prevent the scattering of the garbage or refuse by birds, the breeding of flies, or the entry of rodents. Proper equipment and supplies must be made available to accomplish thorough and proper cleaning of garbage storage areas and receptacles so that unsanitary conditions can be eliminated.		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. Based on observation, interview, and record review, the facility failed to ensure the confidential personal information of residents were protected by failing to ensure documents containing protected health information ([PHI]- any health information that can be used to identify a specific individual which must remain confidential to prevent harmful consequences) were not shredded prior to disposing in the waste container. This failure had the potential to violate 61 of 99 residents' rights for privacy and confidentiality of personal and medical records. Findings: During an observation on 11/18/2025 at 9:35 a.m. of the dishwashing process of [NAME] 1 in the dish machine area, observed [NAME] 1 threw the residents meal tickets in the trash. The meal tickets had residents' names, room numbers, diet orders, and food allergies information. During a concurrent observation and interview on 11/18/2025 at 9:39 a.m. of the dishwashing process with [NAME] 1, [NAME] 1 stated their process of dishwashing was to remove the food and trash including the menu tickets and throw them in the trash. [NAME] 1 stated the trash is taken out and thrown in the dumpster. During an interview on 11/18/2025 at 10:22 a.m. with the Dietary Supervisor (DS), the DS stated the staff throw away the resident's menu tickets in the trash during dishwashing because the menu tickets were wet. However, the diet list (a list of residents' names with their diets, likes, dislikes, allergies and room numbers) were thrown in the confidential box to be shredded. The DS stated the menu tickets contain name, room number and the menu of the day. The DS stated the resident's name is protected information and it had to be protected and placed in a separate area to ensure that people with bad intentions cannot access it. The DS stated the menu tickets should also be protected and needed to be in the confidential bin. The DS stated people can steal residents' identity as a potential outcome of not placing the menu tickets in the confidential bins. During an interview on 11/18/2025 at 2:19 a.m. with the Director of Nursing (DON), the DON stated PHI included name, diet orders, age, and date of birth. The DON stated the meal ticket should have been shredded prior to disposal as it contained PHI. The DON stated other people would know about the residents' names and diets as a potential outcome of not shredding their diet tickets prior to disposal. During a review of the facility's policy and procedure titled Health Insurance Portability and Accountability Act (HIPPA, a federal law that sets national standards to protect medical records and personal health information) dated 1/15/2025, the P&P indicated, To ensure that disclosure of Protected Health Information (PHI) is made consistent with applicable laws, regulations and health information standards, and to ensure that any disclosure of a resident's PHI to a resident's family members, other relatives, close friends or other persons designated by the resident are appropriate. Policy: Disclosure of PHI will only be allowed with a properly completed and signed authorization except: When required or allowed by law As defined in the Notice of Privacy Practices For continuing care (treatment) To obtain payment for services (payment) For the day-to-day operations of the facility and the care given to the residents.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents who were incontinent (lacks voluntary control over urination) of bladder (organ in the pelvis that stores urine) received appropriate treatment and services to prevent urinary tract infections (UTI, common infections that happen when bacteria infect the urinary tract) for three (Resident 42, Resident 118 and Resident 63) of seven residents reviewed under the urinary catheter (a tube that is inserted into the bladder, allowing urine to drain) care area by failing to keep Resident 63, 42 and 118's urinary catheter tubing from coiling and allowing the contents to flow freely into the urinary catheter bag (container that connects to a urinary catheter and collects urine). This deficient practice had the increased potential for Resident 63, 42 and 118 to develop a UTI. Findings: a. During a review of Resident 42's admission Record, the admission Record indicated, the facility initially admitted Resident 42 to the facility on [DATE] and readmitted on [DATE] with diagnoses including cerebrovascular accident (CVA-stroke, loss of blood flow to a part of the brain), neuromuscular dysfunction of bladder (nerve damage to the brain, spinal cord, or nerves that prevents proper bladder function, which can cause difficulty emptying the bladder or involuntary control of urination), and benign prostatic hyperplasia (BPH-enlargement of male reproductive gland). During a review of Resident 42's Minimum Data Set (MDS &ndash; a resident assessment tool), dated 9/3/2025, the MDS indicated, Resident 42 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and is dependent (helper does all the effort) from staff for activities of daily living (ADLs-bed mobility, surface transfer, eating, walk in room, dressing, toileting, and personal hygiene). The MDS indicated Resident 42 was using an indwelling urinary catheter appliance. During a review of Resident 42's Care Plan (CP), dated 12/11/2024, the CP indicated Resident 42 has a Foley Catheter (a type of indwelling urinary catheter) due to neurogenic bladder and BPH. The goal of the CP was for urine to flow freely from the indwelling catheter. The interventions included to check for kinks during ADL care and change catheter as needed for leaking and blockage. During a review of Resident 42's Order Summary, the Order Summary indicated the following order dated 10/17/2025: -Foley Catheter Fr [French &ndash; a unit of measurement in millimeters for the outer diameter of a catheter] 10 x 16 milliliter (ml - a unit of measurement for fluid volume). Reinsert foley catheter sterile tray prn [as needed] if clogged or dislodged. Catheter care every shift per facility policy. During a concurrent observation and interview on 11/17/2025 at 10:30 AM with Certified Nurse Assistant 1 (CNA 1), in Resident 42's room, Resident 42's urinary catheter tubing was looped, preventing the free flow of urine through the tubing and into the collection bag. Resident 42's urinary catheter collection bag was also observed to be hung at the middle portion of the bedside railing. CNA 1 stated, she observed Resident 42's urinary catheter tubing to be looped causing yellow liquid to be filling the tubing and not free flowing into the collection bag. CNA 1 moved the collection bag toward the end length of Resident 42's bed and uncoiled the tubing which then allowed for urine to flow into the collection bag. CNA 1 stated that Resident 42's catheter tubing should not have been looped because the buildup and backflow of urine into Resident 42's bladder could cause a UTI. (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/17/2025 at 11:16 AM with Registered Nurse Supervisor 2 (RN Sup 2), RN 2 Sup stated it is important to prevent the backflow of urine into the bladder to prevent UTIs. During an interview on 11/19/2025 at 9:15 AM with the Director of Nursing (DON), the DON stated it is important to ensure the urinary catheter tubing is not kinked or looped to allow for the free flow of urine into the collection bag to prevent the backflow or urine, which can cause a UTI. During a review of the facility's policy and procedure (P&P), titled, Preventing Catheter Related Urinary Tract Infection, dated 1/2025, the P&P indicated, it is the policy of this facility to ensure appropriate interventions are used for prevention of catheter related UTI. The P&P also indicated, Proper Techniques for Urinary Catheter maintenance should include . maintain unobstructed urine flow. b. During a review of Resident 118's admission Record, the admission Record indicated the facility initially admitted Resident 118 to the facility on [DATE] with diagnoses including chronic respiratory failure status post tracheostomy (surgical opening made in the front of the neck that goes into the windpipe) and ventilator (a medical device to help support or replace breathing), hyponatremia (low sodium in the blood), and end stage renal disease (ESRD-irreversible kidney failure) on hemodialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed). During a review of Resident 118's MDS, the MDS indicated, Resident 118 had severely impaired cognition) for daily decision-making and is dependent from staff for ADLs. The MDS indicated Resident 118 was using an indwelling urinary catheter appliance. During a review of Resident 118's Care Plan (CP) dated 11/17/2025, the CP indicated Resident 118 resident has an indwelling catheter due to neurogenic bladder and BPH. The goal of the CP was for urine to flow freely from the indwelling catheter. The interventions included to check for kinks during ADL care and change catheter as needed for leaking and blockage. During a review of Resident 118's Order Summary, the Order Summary indicated the following order dated 11/12/2025:-Foley Catheter Fr 14 / 30. Reinsert foley catheter sterile tray as needed if clogged or dislodged. Catheter care every shift per facility policy. During a concurrent observation and interview on 11/17/2025 at 11:11 AM with CNA 2 in Resident 118's room, Resident 118's urinary catheter tubing was looped, preventing the free flow of urine through the tubing and into the collection bag. Resident 118's urinary catheter collection bag was observed to be hung in the middle length of the bedside railing. CNA 2 stated he observed Resident 118's urinary catheter tubing to be looped causing yellow liquid to be pooling at the bottom of the loop and not flowing freely into the collection bag. CNA 2 moved collection bag further toward the end length of Resident 42's bed and uncoiled the tubing which then allowed for urine to flow into the collection bag. CNA 2 stated Resident 118's catheter tubing should not have been looped because the coiling of the tubing could cause a backflow of urine into Resident 118, which could cause a UTI. During an interview on 11/17/2025 at 11:16 AM with RN Sup 2, RN Sup 2 stated it is important to prevent the backflow of urine into the bladder to prevent UTIs. During an interview on 11/19/2025 at 9:15 AM with the DON, the DON stated, it is important to ensure the urinary catheter tubing is not kinked or looped to allow for the free flow of urine into the collection (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bag to prevent the backflow or urine, which can cause a UTI. During a review of the facility's P&P, titled, Preventing Catheter Related Urinary Tract Infection, dated 1/2025, the P&P indicated, it is the policy of this facility to ensure appropriate interventions are used for prevention of catheter related UTI. The P&P also indicated, Proper Techniques for Urinary Catheter maintenance should include . maintain unobstructed urine flow. c. During a review of Resident 63's admission Record, the admission Record indicated the facility initially admitted Resident 63 on 6/2/2022 and readmitted on [DATE] with diagnoses including dependence on ventilator (a machine that breathes for you or helps you breathe), gastrostomy (a surgical opening through the skin of the abdomen to the stomach, for a feeding tube) and persistent vegetative state (when a person is in a state of wakefulness but lacks awareness, with no sign of consciousness of themselves or their environment). During a review of Resident 63's History and Physical (H&P), the H&P indicates the resident is in a vegetative state and is not competent to enter into a contract, including an admission agreement. During a review of Resident 63's MDS, dated [DATE], the MDS indicated Resident 63 was rarely/never understood and completely dependent on facility staff for all activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily) During a review of Resident 63's Order Summary Report, dated 11/20/2025, the order summary report indicated Resident 63 had an order dated 8/14/2025 for: Foley Catheter #FR 18(French x10 ml, reinsert FC with sterile tray PRN (as needed) if clogged or dislodged. Catheter care very shift per facility policy, as needed for neurogenic bladder. During a review of Resident 63's FC Care Plan (CP), initiated on 2/27/2023, the CP's goal was for urine to be free flowing from the indwelling catheter while in use. The CP further indicted interventions to position the catheter bag and tubing below the level of the bladder, check tubing for kinks and observe/report to MD signs of a UTI. During an observation, on 11/17/2025, at 10:08 am, inside Resident 63's room, Resident 63 was lying down in bed with a urinary catheter bag hanging on the right side of the resident's bed frame. The urinary catheter tubing hung below the middle-right side of the bed and had coils. The coiled portion of the urinary catheter tubing contained yellow liquid with sediment. During a concurrent observation and interview, on 11/17/2025, at 11:16 am, inside Resident 63's room, with Registered Nurse Supervisor (RN Sup 5), RN Sup 5 confirmed Resident 63's urinary catheter tubing was coiled and contained yellow liquid with white sediment. RN Sup 5 stated the urinary catheter tubing should be straight in order drain the urine into the urinary catheter bag. RN Sup 5 further stated if the urine is not draining properly, the resident can possibly get an infection because the urine might backflow into his body. During an interview with the Director of Nursing (DON), on 11/20/2025, at 12:04 pm, the DON stated the flow of urine should not be obstructed in a urinary catheter because it can cause urinary retention. The DON stated the urinary catheter tubing should not be coiled or kinked and below bladder level. The DON stated if the urinary catheter tubing is coiled, it can possibly become kinked. The DON further stated if urinary retention occurs, bladder distension (when the bladder becomes larger from (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	storing excess urine) and can possibly cause a UTI. During a review of the facility's policy and procedure (P&P) titled, Catheter Care, Indwelling, last reviewed 1/2025, the P&P indicated the policy of the facility is to provide catheter care to reduce the risk of infections. During a review of the facility's policy and procedure (P&P), titled, Preventing Catheter Related Urinary Tract Infection, dated 1/2025, the P&P indicated, it is the policy of this facility to ensure appropriate interventions are used for prevention of catheter related UTI. The P&P also indicated, Proper Techniques for Urinary Catheter maintenance should include . maintain unobstructed urine flow.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to: 1. Ensure Licensed Vocational Nurse 2 (LVN 2) administered Midodrine (a medication used to treat hypotension [low blood pressure]) within the prescribed parameters (a set of defined limits) for one of three sampled residents (Resident 7).[^] This deficient practice had the potential to place Resident 7 at increased risk of experiencing adverse side effects (undesired harmful effect resulting from a medication or other intervention) which can lead to possible medical complications and/or hospitalization.^{^^} 2. Ensure one of three sampled residents (Resident 57) was administered medication in accordance with the physician's orders when the resident's lidocaine patch (a patch applied to the skin that treats pain) was not removed 12 hours after application as ordered.^{^^} This failure had the potential to result in Resident 57 having an adverse reaction to the lidocaine patch including skin irritation and itching at the application site.[^] 3. a. To remove five (5) CMs from Medication Cart 2 after the physician discontinued the orders. b. To reconcile (the process of comparing transactions and activity to supporting documentation) four (4) Controlled Medications ([CM] - medications which have a potential for abuse and may also lead to physical or psychological dependence, also known as Controlled Drugs or Controlled Substances [CS]), in one (1) of three (3) inspected medication Cart (Medication Cart 2). As a result, control and accountability of medications and CMs did not follow state and federal regulations and facility policy and procedures. This deficient practice increased the opportunity for CM diversion (the transfer of a controlled medication or other medication from a lawful to an unlawful channel of distribution or use,) and the risk that residents in the facility could have adverse drug reactions (unwanted, uncomfortable, or dangerous effects that a medication may have, such as coma [a state of deep unconsciousness]) from exposure to harmful medications, leading to physical and psychosocial harm, and hospitalization. Findings:[^] 1. During a review of Resident 7's admission Record (AR), the AR indicated the facility admitted Resident 7 on 9/2/2025 and re-admitted on [DATE] with diagnoses including chronic respiratory failure (a condition in which your blood does not get enough oxygen or has too much carbon dioxide), tracheostomy (an opening surgically created through the neck into the trachea [windpipe] to allow direct access to the breathing tube), and gastrostomy tube (GT- a flexible tube surgically inserted through the abdomen into the stomach for feeding, fluid, and medication administration).^{^^} [^] During a review of Resident 7's Order Summary Report, the Order Summary Report indicated an order dated 9/2/2025 for midodrine hydrochloride 10 milligrams (mg-unit of measurement) one tab via GT three times a day for hypotension and hold if systolic blood pressure (SBP-the upper number in a blood pressure reading, representing the pressure against artery walls when the heart contracts and beats) above 120.^{^^} [^] During review of Resident 7's Minimum Data Set (MDS - a comprehensive standardized assessment and care-screening tool), dated 9/8/2025, the MDS indicated Resident 7 has moderately impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and dependent (helper does all the effort) from staff for activities of daily living (ADLs-bed mobility, surface transfer, eating, walk in room, dressing, toileting, and personal hygiene).[^] (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	^ During a concurrent interview and record review on 11/19/2025 at 4:10 p.m., with the Quality Assurance Nurse (QAN), Resident 7's November 2025 Medication Administration Record (MAR) was reviewed. Resident 7's MAR indicated midodrine was administered on 11/14/2025 at midnight with a documented blood pressure of 121/65. The QAN stated that Resident 7's midodrine dose should not have been administered since the BP was not within the ordered parameters. The QAN stated that it is important to administer medication per physician (MD) order due to possible side effects of the medication.^ ^ During an interview on 11/20/2025 at 12:54 p.m., with the Director of Nursing (DON), the DON stated that all medications should be given per the physician's order and if the blood pressure was outside the parameters, the medication should be held.^ ^ During a review of facility's policy and procedure (P&P), titled, Medication Administration-General Guidelines revised on 1/15/2025, the P&P indicated, under administration Medications are administered in accordance with written orders of the prescriber.^ 2. During a review of Resident 57's admission Record, the admission Record indicated the facility originally admitted the resident on 5/7/2024 and readmitted the resident on 11/8/2025 with diagnoses including, but not limited to, chronic respiratory failure (a condition where the lungs cannot release enough oxygen into the blood)^ with hypoxia (an insufficient amount of oxygen in your body tissues), spinal stenosis (a narrowing of the spinal canal that puts pressure on the spinal cord and nerves, causing symptoms like back and neck pain, numbness, weakness, or cramping in the arms or legs), and functional quadriplegia (paralysis from the neck down, including legs, and arms due to severe disability or frailty).^ ^ During a review of Resident 57's MDS, dated [DATE], the MDS indicated the resident had intact cognition (can think, learn, remember, use judgement, and make decisions). The MDS further indicated Resident 57 was completely dependent on staff or required substantial assistance for most activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily).^ ^ During a review of Resident 57's Order Summary Report, the Order Summary Report indicated an active order dated 8/31/2025 to apply one 4% lidocaine patch to the right shoulder one time a day for pain management and remove per schedule.^ ^ During a review of Resident 57's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 11/2025, the MAR indicated to apply the 4% lidocaine patch at 9:00 a.m. and to remove it at 8:59 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	every day.^ ^ During a review of Resident 57's care plan (a personalized document that outlines an individual's specific health needs, treatments, and goals to ensure they receive appropriate care and support) titled, The resident is at risk for pain., dated 5/7/2024, the care plan indicated to administer pain medications per physician orders.^ ^ During a concurrent observation and interview on 11/19/2025 at 8:00 a.m. with Licensed Vocational Nurse (LVN) 3 and Resident 57, Resident 57 was wearing a lidocaine patch that was dated 11/18/2025. LVN 3 stated she applied that lidocaine patch yesterday morning. Resident 57 stated someone usually removes the patch at night, but no one did this the night before. LVN 3 stated the lidocaine patch should have been removed yesterday in the evening because the order states to remove it after 12 hours.^ ^ During an interview on 11/20/2025 at 1:34 p.m. with the Director of Nursing (DON), the DON stated Resident 57's lidocaine patch should have been removed 12 hours after application following the physician's order. The DON stated the resident could experience adverse effects from the lidocaine patch being left on too long such as blisters, skin irritation, and redness.^ ~~~~ During a review of the facility's policy and procedure (P&P) titled, Medication Administration & General Guidelines, last reviewed on 1/15/2025, the P&P indicated: Medications are administered in accordance with written orders of the prescriber.^ ^ During a review of the manufacturer's instructions for Theracare 4% Lidocaine Pain Relief Patches provided by the facility, the manufacturer's instructions indicated to use the product only as directed. The manufacturer's instructions indicated to use the patch for up to 12 hours.^ 3. During an observation on 11/18/2025 at 2:35 p.m., with Registered Nurse (RN) 4, inside the CM drawer of Medication Cart 2, there were 5 bubble packs (medication cards that contain individual doses sealed in clear plastic bubbles with a foil backing) medications: 1. Three (3) Modafinil (CM commonly used to promote wakefulness) 200 milligrams (mg-unit of measurement for medication) tablets. 2. Seven (7) Modafinil 200 mg tablets. 3. 22 hydrocodone-acetaminophen (CM used to treat severe pain) 5-325 mg tablets. 4. Seven (7) Temazepam (CM used for the short-term treatment of insomnia (trouble with sleeping) 7.5 mg capsules. 5. 36 hydrocodone-acetaminophen 10-325 mg tablets. During a review of Resident 27's admission Record the admission Record indicated the facility originally admitted Resident 27 on 11/12/2016 and re-admitted resident on 10/05/2025, with diagnoses including type 2 diabetes mellitus (a disorder characterized by difficulty in blood sugar (continued on next page)		

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	control and poor wound healing), hypertension (high blood pressure), and hyperlipidemia (high cholesterol level).` During a review of the Resident 27's Order Listing Report, the Order Listing Report indicated an order dated 10/31/2025 for hydrocodone-acetaminophen oral tablet 5-325 mg, 1 tablet by mouth every 6 hours as needed for moderate pain. The Order Listing Report indicated the order was discontinued on 11/13/2025. During a review of Resident 30's admission Record , the admission Record` indicated the facility admitted Resident 30 on 10/31/2025 with diagnoses including Parkinson's disease (disease affects movement due to the loss of brain cells) , insomnia (sleep disorder characterized by difficulty falling or staying asleep, leading to daytime fatigue and irritability), and chronic kidney disease (kidneys are damaged and can't filter blood).During a review of Resident 30's Order Listing Report, the Order Listing Report indicated an order dated 11/02/2025 for temazepam 7.5 mg oral capsule by mouth every 24 hours as needed for insomnia for 14 days.During a review of Resident 92's admission Record, the admission Record`indicated the facility admitted originally Resident 92 on 8/19/2025 and re-admitted the resident on 9/22/2025, with diagnoses including type 2 diabetes mellitus, hypertension, and encephalopathy (any disease or disorder that affects the brain's structure or function).During record review of Resident 92's Order Listing Report, the Order Listing Report indicated an order for modafinil oral tablet 200 mg give 1 tablet by via G tube one time a day for encephalopathy. The Order Listing Report indicated the order was discontinued was on 10/30/2025. During a review of Resident 96's admission Record, the admission Record`indicated the facility originally admitted Resident 96 on 2/21/2023 and re-admitted the resident on 12/28/2024, with diagnoses including dysphagia (difficulty swallowing), hypertensive hearth disease with hearth failure (chronic high blood pressure damages the heart which can no longer pump blood effectively), and hyperlipidemia (high cholesterol level).` During record review of Resident 96's Order Listing Report, the Order Listing Report indicated an order for hydrocodone-acetaminophen oral tablet 5-325 mg give 1 tablet by mouth every four (4) hours as needed for moderate to severe pain. The Order Listing Report indicated the order was discontinued was on 10/09/2025. During a concurrent interview and record review with RN 4 on 11/18/2025 at 2:40 pm, Resident 27, Resident 30, Resident 92, and Resident 96' Order Listing Reports were reviewed. RN 4 stated when a medication order is discontinued, the standard practice is for the licensed nurse to give the discontinued medication to the Director of Nursing (DON) for proper disposal (safely and legally get rid of prescription drugs that are regulated by the government`due to their potential for abuse or addiction). RN 4 stated that this process is followed particularly for controlled substances to ensure safety, regulatory compliance, and to prevent medication errors, including the risk of overdose or accidental administration and diversion. RN 4 further stated CM carries a higher risk for diversion and abuse and therefore require stricter handling procedures. RN 4 stated CMs must be counted at every shift change by two licensed nurses to ensure accountability and to prevent CM diversion. During an interview with the facility pharmacy consultant on 11/19/2025 at 12:48 PM, the facility pharmacy consultant stated when a physician discontinues a medication order, the discontinued medication should be removed from the active supply and placed in a designated area within the medication room. For CM, the expectation is that they are handed directly to DON by the end of the shift or as soon as possible to prevent diversion. CMs have more potential for harm due to abuse and side effects require stricter protocols. The facility pharmacy consultant stated he visits the facility every 30 days, with his last visit on 10/15/2025, during which he disposed of all CM. The facility (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	pharmacy consultant stated that if a CM was discontinued on 10/09/2025, it should have been disposed during his visit on 10/15/2025. The facility pharmacy consultant stated that licensed nurses are required to perform a narcotic count at each shift change, and any medication stored in the narcotic drawer must be accounted for. Failure to do so increases the risk of medication errors and diversion. During review of facility document titled Nursing Staffing Assignment and Sign in Sheet dated 11/18/2025, the document indicated LVN 1 was assigned to Medication Cart 2 from 7 a.m. to 7 p.m. During an interview with Licensed Vocational Nurse (LVN) 1 on 11/19/2025 at 2:09 p.m., LVN 1 stated that he was assigned to Medication Cart 2 during the 7:00 a.m. to 7:00 p.m. shift on 11/18/2025. LVN 1 stated that it is standard practice to count all CM in the CM drawer with the outgoing nurse at the start of the shift, document the count, and sign the narcotic binder to confirm accuracy. However, LVN 1 stated he did not count the five CMs that had been placed with a CM count sheet, as these medications had been discontinued and the corresponding count sheet was not located in the narcotic binder. LVN 1 stated his usual practice is when a CM is discontinued, is to remove both the medication and its count sheet and submit them to the DON to prevent diversion. LVN 1 stated that he forgot to complete this step for the five discontinued medications, resulting in a deviation from protocol. During an interview with the DON on 11/19/2025 at 3:30 PM, the DON stated that at each shift change, or when keys are transferred, a physical inventory of all CM is conducted by two licensed nurses and narcotic binder sign by two licensed nurses to ensure accountability and prevent CM diversion based on facility policy. The DON stated that when a medication order is discontinued, licensed nurses must remove the medication from the active supply and place it in a separate area to reduce the risk of medication errors and diversion. The DON stated although the facility does not have a policy outlined for CM, she had verbally instructed licensed nurses to give all discontinued CM directly to her, which she stores in a locked locker in her office until they are disposed of with the facility pharmacy consultant. The DON acknowledged that on 10/15/ 2025, although the pharmacy consultant was present, she did not dispose of the five discontinued CM. The DON stated that CMs carry a higher risk for diversion and abuse compared to regular medications and therefore require more careful handling. The DON stated facility follows all applicable federal and state regulations regarding controlled substances. During a review of the facility's policy and procedures (P&P), titled Medication Storage in the Facility, Controlled Substance Storage last reviewed on 1/2025 the P&P indicated: Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal and recordkeeping in the facility in accordance with federal, state and other applicable laws and regulations. At each shift change, or when keys are transferred, a physical inventory of all controlled substances, including refrigerated items, is conducted by two licensed nurses and is documented. The emergency supply may be verified by assuring that the seal on the supply has not been broken. (Contents of the emergency narcotic supply is limited by individual state and federal laws). Controlled substances remaining in the facility after the order has been discontinued or the resident has been discharged are retained in the facility in a securely locked area with restricted access until destroyed. Accountability records for discontinued controlled substances are maintained with the unused supply until it is destroyed or disposed of and then stored for 5 years or as required by applicable law or regulation. During a review of the facility's policy and procedures (P&P), titled Disposal of medications and medication-related supplies , Discontinued Medication last reviewed on 1/2025, the P&P indicated: When medications are discontinued by the prescriber or the resident is discharged and medications are not sent with the resident, the medications are marked as discontinued and stored in a secure and separate area from the active supply, marked discontinued and securely stored until destroyed. Some states may have a system in place to donate unused medications to a charitable concern for reuse. Residents whose medications are sent home on discharge are provided (continued on next page)		

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medications in accordance with state laws and regulations, and according to discharge medication policies.		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, and record review, the facility failed to follow the recipe and did not meet the nutritional needs of residents when [NAME] 1 used water instead of warm milk for puree pasta and butter and water instead of milk, gravy, or low sodium broth for puree meat sauce. This failure had the potential to decrease in flavor and nutrient intake of protein and calories resulting in unplanned weight loss to 12 of 99 residents on puree (foods that are smooth and pudding like consistency) diet getting food from the kitchen. Findings: During a review of the facility's daily spreadsheet (a list of food, amount of food that each diet would receive) titled Fall Menus, dated 11/17/2025, the spreadsheet indicated residents on puree diet would include the following foods on the tray: Puree wheat spaghetti 1/2 cup (c, household measurement) Puree zesty meat sauce 6 ounces (oz, a unit of measurement) Puree baked zucchini 1/3 c Puree garlic bread 1/4 c Pudding 1/3 c Milk 4 oz During a concurrent test tray (an area where foods were assembled from the steamtable to resident's plate) observation and interview on 11/17/2025 at 1:32 p.m. of regular diet and puree diet with the Dietary Supervisor (DS), the puree wheat spaghetti and puree zesty meat sauce has less flavor compared to regular diet wheat spaghetti and zesty meat sauce. During a concurrent interview and record review, on 11/17/2025 at 11:45 p.m., with the Dietary Supervisor (DS) and [NAME] 1, the facility's standardized recipe titled, Recipe: Pureed (IDDSI Level #4), Starch (Rice, Pasta, Polenta, Potatoes, etc.) and Recipe: Pureed (IDDSI Level 4) Casserole dated 2025 were reviewed. The recipes indicated, puree zesty spaghetti ingredients are casserole for recipe and warm fluid such as milk, gravy, or low sodium broth and the puree wheat spaghetti ingredients are starch per recipe and warm milk. [NAME] 1 stated she only used water and thickener for cooking puree wheat spaghetti and added a little butter, water and thickener in cooking zesty meat sauce. The DS stated [NAME] 1 should follow the recipes as they were standardized and so that taste would be the same as regular diet. The DS stated residents might not like the food and would not eat resulting in weight loss as a potential outcome of not following standardized recipes. During a review of the facility's policy and procedures (P&P) titled Food Preparation dated 1/15/2025, the P&P indicated Policy: Food shall be prepared by methods that conserve nutritive value, flavor, and appearance. Procedure: (1) The facility will use approved recipes, standardized to meet the resident census. During a review of the facility's diet manual titled IDDSI #4: Regular Puree Diet dated //2025, the diet manual indicated, Detailed recipes and procedures for pureeing foods may be found in Book #1, under the Food Safety/Miscellaneous Section. All foods are to be prepared in a food processor or blender. Additional liquids, such as broth, gravy, vegetables or fruit juices, or milk, and potentially food thickeners are added to achieve the appropriate final consistency. Water is not used because it dilutes flavors and results in a poorly accepted product.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and food preparation practices in the kitchen when: 1. Ice builds up on the freezer pipes and the air curtains in the walk-in freezer. 2. Food storage racks were not six (6) inches above the floor. a. One (1) rack was four (4) inches from the floor, and the other rack was five (5) inches in the walk-in freezer. b. Two (2) racks were 5 inches from the floor in the dry storage area. 3. Kitchen equipment and utensils were not smooth and not free from cracks and chips a. One (1) green rack in the walk-in freezer and 6 green racks in the walk-in refrigerator were not smooth, had cracks and chips, orange and black discoloration and rust. b. Brown, blue and green chopping board had scratches and chips. c. Can opener blade was rusted. 4. Thawed chicken was not labeled correctly and was not used beyond the thaw date or use by date. 5. One (1) dented can by the walk-in freezer and 5 dented cans in the dry storage area were not separated with non-dented cans. 6. Parmesan cheese was 46 degrees Fahrenheit (F, a degree of temperature) and cheese sandwich was at 41.2 F. in the reach in freezer by the oven. 7. Mixer had dirt residues on the mixing bowl and was not cleaned after being used last week. 8. Residents' trays were stacked wet and were not air dried after washing. 9. Residents' refrigerator by station two (2) acceptable range was 36-46 F. November temperature logs indicated temperatures higher than 40 F. These failures had the potential to result in harmful bacterial growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness (a disease caused by consuming food or drinks that are contaminated by germs or chemicals) in 61 of 99 medically compromised residents who received food and ice from the kitchen. Findings: 1. During an observation on 11/17/2025 at 8:32 a.m. in the walk-in freezer, observed a thick ice buildup on the pipes and the air curtains. During a concurrent observation and interview on 11/17/2025 at 8:54 a.m. with the Dietary Supervisor (DS) in the walk-in freezer, the DS stated they maintained the freezer to be ice buildup free so that freezer acceptable temperatures are maintained. The DS stated an outside company checked it and recommended changing the gasket to see if the ice buildup would improve. The DS stated the pipes and curtains had ice buildup and it's not acceptable because it could hinder meeting the acceptable freezer temperatures and food products in the freezer could spoil. The DS stated if the residents were served spoiled food, they could get sick. During a review of the policies and procedures (P&P) titled Refrigerator and Freezer dated 1/15/2025, the P&P indicated Maintaining a clean refrigerator and freezer can improve the safety and quality of your foods. (3) Clean evaporator and condensing coils at least twice a year. 2. a. During an observation on 11/17/2025 at 8:32 a.m., of the walk-in freezer, observed 2 racks not 6 inches from the floor. During a concurrent observation and interview on 11/17/2025 at 8:59 a.m. with the DS, the DS stated the rack in the walk-in freezer was falling off as they placed heavy meat there. The DS stated the height of the rack for the meat was 4 inches and the other rack was 5 inches. The DS stated she was not sure of the storage racks requirements and would check. During an interview on 11/17/2025 at 9:05 a.m. with the DS, the DS stated the height of the racks in the storage areas should be 6 inches or more from the floor to facilitate cleaning. The DS stated since the 2 racks in the walk-in freezer were not 6 inches, staff would not be able to clean properly causing mold growth under the racks. The DS stated residents could get sick of weight loss and infection as a potential outcome of cross-contamination. During a review of the facility's P&P titled Procedure for Freezer Storage dated 1/15/2025, the P&P indicated 10. All food and food containers are to be stored 6 off the floor and 18 from sprinkler heads, if applicable. Food items should be stored on clean surfaces in a manner that protects it from contamination. b. During a concurrent observation and interview on 11/17/2025 at 9:34 a.m. of the racks in the dry storage area with the DS, observed 2 racks were at 5 inches (measured using tape measure) from the floor. The DS stated they needed to adjust the racks to 6 inches to facilitate cleaning in the kitchen and prevent residents from getting sick. During a (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	review of the facility's P&P titled Storage of Food and Supplies, dated 1/15/2025, the P&P indicated All shelves and storage racks or platforms should be in accordance with state and federal regulations to facilitate air circulation and promote easy and regular cleaning. Shelves and cupboards will not be lined with shelf paper or other liners. All food and food containers are to be stored 6 off the floor and on clean surfaces in a manner that protects it from contamination. During a review of Food Code 2022 dated 1/18/2023 the Food Code 2022 indicated 3-305.11 Food Storage (A) Except as specified in (B) and (C) of this section, food shall be protected from contamination by storing the food: (3) at least 15 cm (6 inches) above the floor. 3. a. During an observation on 11/17/2025 at 8:36 a.m. of the green racks in the walk-in refrigerator, observed 6 of 6 green racks had chips, paint coming off and rusted. During a concurrent observation and interview on 11/17/2025 at 8:56 a.m. with the DS, the DS stated the racks with cracks and chips in the walk-in refrigerator were not acceptable because of the rust. The DS stated the cracks and paint residues could go to the food and residents could get sick. The DS stated racks should have a smooth surface so they could easily clean it, if not bacteria could grow and residents could get sick from the bacterial growth in food as a potential outcome. During a review of the facility's P&P titled Refrigerator and Freezer dated 1/15/2025, the P&P indicated, 9. Periodically inspect shelves and replace if coating is chipped away exposing metal shelves. b. During an observation on 11/17/2025 at 12:15 p.m. of the chopping board, observed 2 brown chopping boards, 2 green chipping boards and 1 blue chopping board had scratches. During a concurrent observation and interview on 11/18/2025 at 10:14 a.m. of the chopping board with the DS, the DS stated the chopping board should have no old lines and scratches because contaminants can stay in the chopping board scratches. The DS stated cross-contamination could happen and residents could get sick of diarrhea, nausea, vomiting and tummy ache. During a review of the facility's P&P titled Maintenance of Kitchen Supplies (Cutting Boards, Ladles, Scoopers, Utensils) dated 1/15/2025, the P&P indicated To ensure all dietary equipment and food-contact utensils (e.g., cutting boards, ladles, scoopers, spatulas, tongs) are clean, safe and maintained in good working condition to prevent contamination and ensure compliance with state, federal, and facility standards. All food-contact equipment and utensils must be cleaned, sanitized, inspected, and maintained to ensure structural integrity and safe use. Damaged, worn, or non-sanitizable items must be removed from service immediately. Staff are responsible for proper cleaning and reporting concerns and supervisors are responsible for monitoring and documentation. During a review of Food Code 2022, dated 1/18/2023 the Food Code 2022 indicated, 4-501.12 Cutting Surfaces. Cutting surfaces such as cutting boards and blocks that become scratched and scored may be difficult to clean and sanitize. As a result, pathogenic microorganisms transmissible through food may be transferred to foods that are prepared on such surfaces. c. During an observation on 11/17/2025 at 12:18 p.m. of the commercial can opener, observed amber discoloration and rust on the blade of the commercial can opener. During a concurrent observation and interview on 11/18/2025 at 10:17 a.m. of the manual can opener, the DS stated the can opener was not in use because it had rust, but it needed to be removed from the kitchen to prevent cross-contamination. During a review of the facility's P&P titled Maintenance of Kitchen Supplies (Cutting Boards, dated 1/8/2025, the P&P indicated (1) Dietary staff must visually inspect all utensils and cutting boards daily before use. (2) Inspect for: rust, pitting, or discoloration During a review of Food Code 2022, dated 1/18/2023 the Food Code 2022 indicated, 4-202.11 Food-Contact Surfaces. (A) Multiuse Food-contact surfaces shall be (1) Smooth (2) Free of breaks, open seams, cracks, chips, inclusions, pits, and similar imperfections. (3) Free of sharp internal angles, corners, and crevices, (4) Finished to have smooth welds and joints. 4. During an observation on 11/17/2025 at 8:36 a.m., of the thawed chicken in the walk-in refrigerator, observed thawed chicken dated 11/11/2025. During an interview on 11/17/2025 at 9:13 a.m. with the DS and [NAME] 1, the DS stated the staff label and date the food products with the following: Delivery date Open date Best buy date or expiration date. The DS stated any food product that passed the expiration date and best buy date staff throw and discard. The DS stated the process of thawing included staff placing the frozen (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	items from the freezer to the refrigerator and they have three (3) days before they can use it. The DS stated they need to cook thawed products within 3-4 days. [NAME] 1 stated they pull the frozen product from the freezer and label the product with a pull date then they have 3-4 days to cook the thawed product. The DS stated they cannot use the food beyond 4 days as it might be spoiled already. The DS stated though it was most likely mislabeled by the PM cook they will toss the thawed chicken to prevent salmonella growth that could make residents sick of upset stomach, vomiting and diarrhea upon consumption of the chicken. During a review of the facility's P&P titled Procedure of Freezer Storage, dated 1/15/2025, the P&P indicated, 8. Frozen food should be left in the refrigerator to thaw. Also, see Thawing of Meat policy (section 7, page 7.4-7.5). Once thawed, uncooked meats are to be used within 2 days. Exception is cured meats, to be used within 5 days. During a review of the facility's P&P titled Thawing of Meats dated 1/15/2025, the P&P indicated (1) In a refrigerator at 41 F or colder. Allow 2 to 3 days to defrost, depending on quantity and total weight of meat. Label defrosting meat and pull and use by date. During a review of the facility's P&P titled Labeling and Dating Foods: dated 1/15/2025, the P&P indicated All food items in the storeroom, refrigerator, and freezer need to be labeled and dated. During a review of Food Code 2022, the Food Code 2022 indicated, 3-501.17 Commercially processed food, open and hold cold, (B) except specified in (E) - (G) of this section, refrigerated, ready-to-eat time/temperature control for food safety food prepared and packed by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacture's use-by-date if the manufacturer determined the use-by-date based on food safety. 5. During an observation on 11/17/2025 at 8:49 a.m. of the storage rack by the walk-in freezer, observed 1 dented can stored with non-dented cans. During a concurrent observation and interview on 11/17/2025 at 9:22 a.m. in the dry storage area with the DS, observed 5 dented cans were not separated from the non-dented cans. The DS stated the dented cans should be separated from the non-dented can for the staff to avoid using the canned goods as it might have holes that could spoil food due to bacterial growth. The DS stated residents could get sick of vomiting and diarrhea from eating foods from dented cans as a potential outcome. During a review of the facility's P&P titled Food Storage-Dented Cans dated 1/15/2025, the P&P indicated Food in unlabeled, rusty, leaking broken containers or cans with side seam dents, rim dents, or swells shall not be retained or used by the facility. All dented cans (defined as side seam or rim dents) and rusty cans are to be separated from remaining stock and placed in a specified labeled area for return to purveyor for refund. All leaking cans are to be disposed of immediately. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 3-101.11 Safe Unadulterated, and Honestly Presented. Food shall be safe, unadulterated, and, as specified under 3-601.12, honestly presented. 3-201.11 Compliance with Food Law. A primary line of defense ensuring that food meets the requirements of S3-101.11 is to obtain food from approved sources, the implications of which are discussed below. However, it is also critical to monitor food products to ensure that, after harvesting, processing, they do not fail victim to conditions that endanger their safety, make them adulterated, or compromise their honest presentation. The regulatory community, industry, and consumers should exercise vigilance in controlling the conditions to which foods are subjected and be alert to signs of abuse. FDA considers food in hermetically sealed containers that are swelled or leaking to be adulterated and actionable under the Federal Food, Drug, and Cosmetic Act. Depending on the circumstances, rusted, and pitted or dented cans may also present a serious potential hazard. 6. During an observation on 11/17/2025 at 11:49 a.m. of the food temperatures of the food inside the reach in refrigerator by the oven, observed parmesan cheese at 46 F and egg sandwich at 41.2 F. During a concurrent observation and interview on 11/17/2025 at 11:52 a.m. of the food temperatures (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	in the reach in refrigerator with the DS, the DS stated the parmesan cheese was at 42 F and 41.8 F using the facility thermometer. The DS stated the acceptable food temperatures for cold food is 40 F and below. The DS stated they needed to maintain the temperature of cold food to acceptable temperatures because bacteria could grow if it is outside the range causing residents to get sick upon consuming the food as a potential outcome. During a review of the facility's P&P titled Meal Service dated 1/15/2025, the P&P indicated 4. Cold food items will be placed on the trays as close as serving time as possible to assure the temperature is below 41 F. To accomplish this, all cold foods will be pre-poured and kept in the refrigerator or freezer and pulled out in small quantities sufficient to maintain proper temperature. During a review of Food Code 2022, the Food Code 2022 indicated, 3-501.16 Time/Temperature for Safety Food, Hot and Cold Holding. (A) Except during preparation, cooking, or cooling, or when time is used as a public health control as specified under 3-501.19, and except as specified under (B) and in (C) of this section, Time/Temperature Control for safety food shall be maintained: (2) At 5 C (41 F) or less. 7. During an observation on 11/17/2025 at 12:21 p.m. of the mixer, observed a soiled towel inside the mixing bowl and the mixer was not covered. During a concurrent observation and interview on 11/18/2025 at 10:21 a.m. of the mixer with the DS and [NAME] 1, the DS stated there were food particles spill in the mixing bowl from the food preparation area. [NAME] 1 stated the mixer bowl is cleaned every after use and they washed the bowl. The DS stated the mixer needed to be covered with white plastic after washing when not in use to avoid food spill and cross-contamination. During a review of the facility's P&P titled Electrical Food Machines dated 1/15/2025, the P&P indicated Keep and maintain all food machines in good operating, sanitary condition. This includes mixers, grinders, slicers and toasters. Mixing machines: (1) Wash the bowl and beater after each use. (5) When not in use, mixer should be covered. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 4-601.11 (A) Equipment Food Contact Surfaces and utensils shall be cleaned: (1) Except as specified in (B) of this section, before use with a different type of raw animal food such as beef, fish, lamb, pork or poultry; (2) Each time there is a change from working with raw foods to working with ready-to-eat food; (3) Between uses with raw fruits and vegetables and with time/temperature control for safety food. (4) Before using or storing a food temperature measuring device, and (5) At the time during the operation when contamination may have occurred. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 4-602.13 Nonfood-Contact Surfaces. Nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. 8. During an observation on 11/18/2025 at 10 AM of the trays in the dishwashing area, observed clean trays were stacked wet and had water particles. During a concurrent observation and interview on 11/18/2025 at 10:04 a.m. with the DS, the DS stated the trays were stacked wet and the staff needed to dry the trays separately to avoid moisture because when there is moist there would be bacterial growth. The DS stated there could be cross contamination of food as a potential outcome of not air drying the trays. During a review of the facility's P&P titled Dishwashing dated 1/15/2025, the P&P indicated All dishes will be properly sanitized through the dishwasher. The dishwasher will be kept clean and in good working order. (5) Dishes are to be air dried in racks before stacking and storing. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 4-901.11 Equipment and Utensils, air-drying required. After cleaning and sanitizing equipment and utensils: (A) Shall be air-dried or used after adequate draining as specified in the first paragraph of 40 CFR 180.940 tolerance exemptions for active and inert ingredients for use in antimicrobial formulations (food-contact surface sanitizing solutions), before contact with food and; (B) May not be cloth dried except that utensils that have been air-dried may be polished with cloths that are maintained clean and dry. 9. During a concurrent observation and interview on 11/18/2025 at 10:51 a.m. of the resident's refrigerator with the DS and Registered Nurse Supervisor 1 (RNS 1), observed temperature log posted indicated acceptable refrigerator temperature range was 36-46 F. RNS 1 stated they monitor the residents' refrigerator temperature two times a day in the morning and afternoon and the acceptable temperature range is (continued on next page)		

Department of Health & Human Services
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	36-46 F. The DS stated they use 36-40 F for food refrigerator as they have danger zone (the temperature range of 41-135 F where bacteria grow and multiply rapidly) of food to avoid. The DS stated the danger zone of cold food is 41-75 F and bacteria started to grow in food in these temperatures. The DS stated when bacteria grow in food, it could spoil food and residents could get sick of stomach pain, diarrhea and vomiting when eating spoiled food. During a review of the facility' temperature log titled Refrigerator Temperature Log dated 11/2025, the log indicated the following temperatures were more than 41 F on the following dates and there was no corrective action done: 11/2/2025: 43 F at 7p.m. 11/4/2025: 42 F at 7 a.m.; 43 F at 7 p.m. 11/7/2025: 42 F at 7 a.m. 11/9/2025: 43 F at 7 a.m. 11/10/2025: 42 F at 7 a.m.; 42 F at 7 p.m. 11/13/2025: 42 F at 7 a.m. During a review of the facility's P&P titled Cold Storage Temperature Monitoring and Record Keeping dated 1/15/2025, the P&P indicated Refrigerator temperature standard are less or equal to 41 F. The goal is to keep the temperature at 34 F-39 F. This will allow for a 2 rise in temperature when the door is opened throughout the day. This will also keep the food at less than 41 F. During a review of the facility's P&P titled Procedure for Refrigerated Storage dated 1/15/2025, the P&P indicated (1) Refrigerated - 41 F or lower. To keep food at a specific temperature, the air temperature in the refrigerator usually must be about 2 F lower. For example, to hold chicken at 41 F, the air temperature must be 39 F.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of 25 sampled residents (Resident 74's) diagnosis of depression was reflected in the resident's list of diagnoses in the Minimum Data Set (MDS - a resident assessment tool). This failure resulted in Resident 74 having an inaccurate MDS assessment. Findings: During a review of Resident 74's admission Record, the admission Record indicated the facility admitted the resident on 5/22/2024 with diagnoses including, but not limited to, chronic respiratory failure (a condition where the lungs cannot release enough oxygen into the blood) with hypoxia (an insufficient amount of oxygen in your body tissues) and end stage renal disease (ESRD, irreversible kidney failure). During a review of Resident 74's MDS, dated [DATE], the MDS indicated the resident had intact cognition (can think, learn, remember, use judgement, and make decisions). The MDS indicated Resident 74 reported having little interest or pleasure in doing things and felt down, depressed, or hopeless. The MDS further indicated Resident 74 required moderate or substantial assistance for most activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). The MDS did not indicate the resident had depression under the Active Diagnoses section. During a review of Resident 74's psychiatric progress note, dated 9/23/2024, the psychiatric progress note indicated Resident 74 had an episode of major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) and would start Lexapro (an antidepressant medication) due to depression manifested by verbalization of sadness. During a review of Resident 74's Order Summary Report, the Order Summary Report indicated an active order dated 9/22/2025 to administer one Lexapro 10 milligram tablet at bedtime every night for depression manifested by persistently verbalizing sadness. During a review of Resident 74's care plan (a personalized document that outlines an individual's specific health needs, treatments, and goals to ensure they receive appropriate care and support) titled, The resident has a behavior of Depression m/b (manifested by) persistently verbalizing sadness., dated 9/11/2024, the care plan indicated a goal to have decreased episodes of depression. During a concurrent interview and record review on 11/20/2025 at 11:10 a.m. with Minimum Data Set Coordinator (MDSC) 1, Resident 74's MDS, dated [DATE], did not indicate a diagnosis of depression under the Active Diagnoses section. MDSC 1 stated the diagnosis of depression should be in the MDS because Resident 74 is taking an antidepressant and is diagnosed with depression. During an interview on 11/20/2025 at 1:34 p.m. with the Director of Nursing (DON), the DON stated Resident 74's MDS should include the diagnosis of depression, so the MDS has all the information needed as that is how they populate the plan of care. For example, due to having a depression diagnosis they would want to encourage Resident 74 to participate in activities, be out of bed, and encourage interaction with visitors. During a review of the facility's policy and procedure (P&P) titled, Resident Assessment Instrument Process, last reviewed on 1/15/2025, the P&P indicated the purpose of the policy is to establish a process to complete accurate and timely assessments that reflect the resident's needs and support appropriate care planning.		

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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. Based on interview and record review, the facility failed to develop and implement a comprehensive care plan based on the resident's individual assessed needs for one of 25 sampled residents (Resident 7) by failing to develop a care plan addressing Resident 7's use of Midodrine (a medication used to treat hypotension [low blood pressure]). This deficient practice had the potential to negatively affect the provision of care and services provided to Resident 7. Findings: During a review of Resident 7's admission Record, the admission Record indicated the facility originally admitted Resident 7 on 9/2/2025 and re-admitted Resident 7 on 10/4/2025 with diagnoses including chronic respiratory failure (a condition in which your blood does not get enough oxygen or has too much carbon dioxide), tracheostomy (an opening surgically created through the neck into windpipe to allow direct access to the breathing tube), and gastrostomy tube (GT- a flexible tube surgically inserted through the abdomen into the stomach for feeding, fluid, and medication administration). During review of Resident 7's Minimum Data Set (MDS - a comprehensive standardized assessment and care-screening tool), dated 9/8/2025, the MDS indicated Resident 7 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and dependent (helper does all the effort) on staff for activities of daily living (ADLs-bed mobility, surface transfer, eating, walk in room, dressing, toileting, and personal hygiene). During a review of Resident 7's Order Summary Report, the Order Summary Report indicated an order dated 9/2/2025 for midodrine hydrochloride (Hcl) 10 milligrams (mg-unit of measurement) one tablet 9 (tab) via GT three times a day for hypotension and hold if systolic (the top number in a blood pressure reading that represents the pressure in the arteries when the heart contracts and pumps blood out) blood pressure (SBP) is above 120 millimeters of mercury (mmHg-unit of pressure). During a concurrent interview and record review on 11/20/2025 at 10:06 a.m., with the Quality Assurance Nurse (QAN), Resident 7's Care Plans (CPs) were reviewed. The QAN stated Resident 7 did not have a care plan for midodrine but one should have been developed to ensure the resident received the appropriate care, as midodrine is considered a high-risk medication. During an interview on 11/20/2025 at 12:54 p.m., with the Director of Nursing (DON), the DON stated that there should be a care plan developed for midodrine when the physician ordered it for Resident 7. During a review of facility's policy and procedure (P&P), titled, Care Plans, Comprehensive Person-Centered, revised on 10/1/2025, the P&P indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. P&P also indicated, The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required comprehensive assessment (MDS).		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, the facility failed to ensure a resident receives 31% Fraction of Inspired Oxygen (proportion of oxygen in the air mixture that is delivered to a patient) via a mist collar (medical device that delivers humidified air or oxygen to a patient's airway through a tracheostomy [an opening created at the front of the neck so a tube can be inserted into the windpipe to help you breathe]) tube as ordered by the physician for one of one resident (Resident 103). This deficient practice had the potential to cause Resident 103 to have shortness of breath that could lead to hypoxemia (a low level of oxygen in the blood). Findings: During a review of Resident 103's admission Record, the admission Record indicated that the facility originally admitted the resident on 7/17/2020 and readmitted the resident on 3/21/2024, with diagnoses including chronic respiratory failure (condition in which not enough oxygen passes from your lungs into your blood) and encounter for attention to tracheostomy. During a review of Resident 103's Minimum Data Set (MDS - a resident assessment tool) dated 10/14/2025, 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. The MDS indicated that Resident 103 was dependent on staff (helper does all of the effort) for toileting hygiene, showering and bathing, lower body dressing, and putting on/taking off footwear. During an observation on 11/17/2025 at 10:04 a.m., observed Resident 103 in bed sleeping. Observed Resident 103 with a tracheostomy and an attached trach mask for supplemental oxygen. Observed Resident 103's oxygen was set at one (1) liter per minute (LPM- unit of measurement for oxygen). During an observation on 11/17/2025 at 10:33 a.m., with the Respiratory Therapist Director (RTD), observed Resident 103's oxygen concentrator set at one (1) LPM. During an interview on 11/19/2025 at 10:25 a.m., with the Quality Assurance Nurse (QAN), the QAN stated that if a resident is not getting the right amount of oxygen as prescribed, it can result in low oxygen level which can lead to shortness of breath and hospitalization. During a concurrent interview and record review on 11/20/2025 at 10:38 a.m., with the RTD, reviewed Resident 103's Order Summary Report (physician orders) dated 3/21/2024. Resident 103's Order Summary Report indicated the following: - Respiratory Treatment: blow by mist collar at 31% as patient tolerated during daytime, every day shift. - Respiratory Treatment: Respiratory Therapist to titrate (to carefully adjust the amount of oxygen a resident receives to achieve a specific, target level of oxygen saturation [amount of oxygen circulating in your blood] in the blood) FiO2 to keep oxygen saturation above 92%. Check oxygen saturation every shift. The RTD stated that Resident 103's oxygen setting of one (1) LPM observed was not the correct setting to achieve an FiO2 of 31% and to maintain oxygen saturation at 92%. The RTD stated Resident 103's oxygen should be set at 2 to 2.5 LPM. The RTD stated that with the setting at one (1) LPM, Resident 103 can experience shortness of breath and oxygen saturation can go down resulting in respiratory distress. During a review of Resident 103's Care Plan (a document that summarizes a resident's needs, goals, and care/treatment) for altered respiratory status/difficulty breathing, initiated on 12/23/2024, the care plan indicated a goal that the resident's oxygen saturation will remain above 92 % through the review date. The care plan interventions were to administer oxygen via tracheostomy mask at 31% at daytime. During a review of the facility's Policy and Procedure (P&P) titled, Fractioned of Inspired Oxygen (FiO2), reviewed on 1/15/2025, the policy and procedure indicated that for all supplemental oxygen delivery devices, the patient is not just breathing the direct oxygen but rather is breathing a combination of room air plus the oxygen from the supplemental device. The oxygen tank flow rate in liters per minute and the equivalent percentage of the FiO2 are the following: 0 (no Oxygen, just room air) = 20% 4 L/min = 24 to 28% 6 L/min= 31% 8 L/min= 35 to 40 %		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow their policy by failing to ensure documentation of completion of training/competency for one of three sampled hemodialysis (HD- the removing of waste and excess fluid to prevent build up in the body for residents who have loss of kidney [organs that remove waste products from the blood and produce urine] function) staff (Hemodialysis Technician [HD Tech]). This deficient practice violated the facility's policy and procedures (P&P), titled, Personnel Files, and had the potential for providing unsafe care to dialysis residents and as well as safety risk for both residents and staff. Findings: During a review of the facility's hemodialysis agreement (FHA) between the facility and the hemodialysis company (HDC) titled, Home Dialysis Care Coordination and Services Agreement, dated [DATE], the FHA indicated, HDC will submit to facility written evidence satisfactory to facility of the qualifications and experience of each HDC representative who is to provide training, support services or dialysis treatment under this agreement, as well as the qualifications of HDC itself. Evidence of qualifications shall include documentation of training, licensure, cardiopulmonary resuscitation (CPR-refers to any medical intervention used to restore circulatory and/or respiratory function that has stopped) certification and abuse prohibition training as required for the facility. During a concurrent interview and record review on [DATE] at 2:14 p.m., with the Director of Staff Development (DSD) and the Assistant Director of Staff Development (ADSD), the HD Tech's staff file was requested. The HD Tech's staff file indicated missing. The DSD and the ADSD stated that they have not done the HD Tech's file at this time. The DSD stated that the HD Tech has been working but unsure of the HD Tech's start date. The DSD stated that Hemodialysis Registered Nurse (HD RN) was supposed to notify and email new HD staff information to the facility prior to start of resident care to be able to provide new HD staff the needed training/competency with the facility's P&P. During an interview on [DATE] at 12:54 p.m., with the Director of Nursing (DON), the DON stated that it is important that facility has all contracted staff files for everyone's safety as well as completion of training regarding facility's P&P should be done prior to start of resident care. During a review of facility's P&P titled, Personnel Files, reviewed on [DATE], the P&P indicated, Facility will ensure that employees and contracted staff's personnel records will be maintained accurate, complete and in regulatory compliance. The P&P also indicated, Required documentation vendors must provide prior to assignment and Contractors must submit to facility: Verification of background check compliance Tuberculosis (TB)/health screening records Professional license verification Competency validation of skills checklist Proof of orientation or competency in required procedures Mandatory training completion (abuse reporting, infection control, fire and disaster, HIPAA [Health Insurance Portability and Accountability] and resident rights) Proof of insurance (if applicable) Agency contract specifying responsibilities		

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow their policy and procedure by failing to ensure that providers signed telephone orders within five (5) days for two of four sampled residents (Resident 27 and Resident 92). This deficient practice resulted in a deviation from the facility's own policy and had the potential to cause delays in necessary services and continuity of care. Findings:^^^ a. During a review of Resident 27's admission Record, the admission Record indicated the facility originally admitted Resident 27 on 11/12/2016 and re-admitted the resident on 10/5/2025, with diagnoses including type two (2) diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing), hypertension (high blood pressure [the force of the blood pushing on the blood vessel walls is too high]), and hyperlipidemia (abnormally high concentration of fats in the blood). During a review of Resident 27's Minimum Data Set (MDS - a resident assessment tool) dated 10/11/2025, 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). During a review of Resident 27's physician telephone order form dated 11/13/2025 and timed 4:56 p.m., the physician order form indicated to discontinue hydrocodone-acetaminophen (medication used to treat moderate to severe pain) oral tablet 5-325 milligrams (mg- unit of measurement) give one (1) tablet by mouth every six (6) hours as needed for moderate pain. The physician telephone order form included a designated line for the physician's signature, which was left blank. During a concurrent interview and record review on 11/20/2025 at 10:59 a.m., with the Director of Nursing (DON), reviewed Resident 27's physician telephone order dated 11/13/2025, and timed 4:56 p.m. The DON stated Resident 27's physician telephone order form included a designated line for the physician's signature, which was left blank. The DON stated the signature of the prescriber is missing. b. During a review of Resident 92's admission Record, the admission Record indicated the facility originally admitted Resident 92 on 8/19/2025 and re-admitted the resident on 9/22/2025, with diagnoses including type 2 diabetes mellitus, hypertension, and encephalopathy (any disease or disorder that affects the brain's structure or function).^^ During a review of Resident 92's MDS dated [DATE], the MDS indicated that the resident's cognitive skills for daily decision making was severely impaired (decisions are not consistent/reasonable). During a review of Resident 92's physician telephone order dated 10/30/2025 and timed 12:00 p.m., the physician order indicated to discontinue modafinil (medication used to treat excessive tiredness caused by certain sleep conditions) oral tablet 200 mg give one (1) tablet by via G tube one time a day for encephalopathy. The telephone order has a blank line for the physician to sign which was left blank. During concurrent interview and record review on 11/20/2025 at 11:05 a.m., with the DON, reviewed Resident 92's physician telephone order dated 10/30/2025 and timed 12:00 p.m. The DON stated Resident 92's physician telephone order form included a designated line for the physician's signature, which was left blank. The DON stated the signature by the prescriber is missing. The DON stated that based on the facility's policy, all physician telephone orders must be signed by the prescriber within five (5) days to ensure clarity and prevent potential miscommunication. Furthermore, the DON emphasized that any physician-related form lacking signature holds no legal standing. During a concurrent interview and record review on 11/20/2025 at 12:05 p.m., with Resident 92's Nurse Practitioner (NP), reviewed Resident 92's physician telephone order dated 10/30/2025 and timed 12:00 p.m. The NP stated he (NP) is Resident 92's provider and he was the one who placed a telephone order to discontinue modafinil oral tablet 200 mg give 1 tablet by via G-tube one time a day for encephalopathy. The NP stated he has access to electronic signatures and stated based on the facility's policy, he must sign any telephone orders within five (5) days to verify that nurses placed the correct order to prevent medical errors. The NP stated all orders, new, (continued on next page)		

Department of Health & Human Services
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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 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	discounted, and mobile phone orders, should be reviewed and signed within five (5) days. The NP stated there is possibility that nurses may enter the order incorrectly which can lead to medication administration errors and potential harm. During a review of facility's policy and procedure (P&P) titled, Physician Services, reviewed on 1/15/2025, the policy indicated, It is the policy of the facility to require that physician services shall be provided in accordance with applicable state laws and regulations. All patients must be under the continuing supervision of an attending physician upon admission, as well as while a resident of this facility. Any and all verbal orders, including telephone orders, should be signed by the prescriber within five (5) days.		

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation, interview and record review, the facility failed to ensure nurse staffing information was posted daily (on 11/17/2025).As a result, the resident census and the actual hours worked by licensed and unlicensed nurses were not readily accessible to residents and visitors.Findings: During an observation on 11/17/2025 at 1:45 p.m., observed in front of nursing station 2, a facility document titled, Nursing Staff Per Shift and Hours, dated 11/15/2025 was posted. During an interview on 11/19/2025 at 2:14 p.m., with the Director of Staff Development (DSD) and Assistant Director of Staff Development (ADSD), the DSD and ADSD stated that they (DSD and ADSD) should update the Nursing Staff Per shift and Hours daily indicating the current resident census and nursing hours at the beginning of each shift and before their shift ends and post the staffing information in the nursing stations. The DSD stated that staff responsible for posting the staffing information on the weekends forgot to update the posting in the morning of 11/17/2025. During an interview on 11/20/2025 at 12:54 p.m., with the Director of Nursing (DON), the DON stated that it is important to update and post the nursing staffing information daily to show the nursing hours being provided to the residents. During a review of facility's policy and procedure (P&P), titled, Nursing Hours Posting revised on 1/15/2025, the P&P indicated, The facility shall post daily nurse staffing information in accordance with Federal Regulations. The daily posting must include the federal required elements: Facility Name Date Resident Census Total Number of Registered Nurse, Licensed Vocational Nurse and Certified Nursing Assistants on duty Total hours worked by each category Administrator or designee contact informationPlace posting in a highly visible public area and it must be clear, accessible, and readable to residents, families, and staff.		

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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** Based on interview and record review, the facility failed to ensure residents were free of any significant medication errors when licensed nurses failed to ensure bumex (medication used to get rid of extra water and salt through the urine) and/or carvedilol (blood pressure [BP] and heart rate lowering medication) were readily available on three different days in September 2025 for one of five residents (Resident 6) during a an unnecessary medication investigation. This deficient practice resulted in Resident 6 not receiving bumex and/or carvedilol on three different days in 09/2025. Findings: During a review of Resident 6's admission Record, the admission Record indicated the facility initially admitted Resident 6 on 2/17/2015 and readmitted on [DATE] with diagnoses including congestive heart failure (CHF - when the heart muscle can't pump enough blood to meet the body's needs), dysphagia (difficulty swallowing), and dementia (a progressive state of decline in mental abilities). During a review of Resident 6's History and Physical (H&P), dated 2/4/2025, the H&P indicated Resident 6 can make her needs known, but cannot make medical decisions. During a review of Resident 6's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 9/5/2025, the MDS indicated Resident 6 rarely understood others and rarely was able to make herself understood. The MDS indicated Resident 6 was dependent on staff for activities of daily living such as toileting, dressing, and putting on/taking off footwear. During a review of Resident 6's Order Summary Report, the order summary report indicated the following orders dated 9/3/2024:- Bumex Oral Tablet Give 1 mg (milligram - unit of measurement) by mouth one time a day for CHF. -Carvedilol Oral Tablet (medication used to treat serious heart conditions by lowering blood pressure and heart rate) 12.5 mg. Give 1 tablet by mouth two times a day for HTN (hypertension - high blood pressure). Hold for SBP (systolic blood pressure - the first/top number in a blood pressure reading) <110 (less than 110) or HR (heart rate) <60. During a review of Resident 6's 9/2025 Electronic Medical Administration Record (EMAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident). the EMAR indicated the following entries: -On 9/1/2025 the box for the 9 am dose of Bumex was documented with 9.-On 9/8/2026 the box for the 5 pm dose of Carvedilol was documented with 9.-On 9/9/20205 the box for the 5 pm dose of Carvedilol was documented with 9. During a review of Resident 6's Progress Notes, the Progress Notes indicated the following entries:-On 9/1/2025, Bumex oral tablet 1 mg, pending on pharmacy.-On 9/9/2025, Carvedilol oral tablet 12.5mg, pending on pharmacy. -On 9/9/2025, Carvedilol oral tablet 12.5mg, pending on pharmacy. During a concurrent interview and record review on 11/19/2025 at 10:55 am with the Assistant Director of Nursing (ADON), Resident 6's 9/2025 EMAR and Progress Notes were reviewed. The ADON stated a check mark in the EMAR indicates the medication was given and a 9 indicates the medication was not given and to refer to the progress notes for the reason why it was not given. The ADON stated pending on pharmacy, indicates the medication is not available and the facility is waiting for the medication to be delivered. The ADON stated licensed nurses must reorder medications when the resident has five days of medication left to allow adequate time for physician verification and delivery. The ADON stated Resident 6 had a history of CHF and those medications (Bumex and Carvedilol) are necessary to prevent CHF exacerbation (a sudden worsening of heart failure symptoms). The ADON further stated that the facility is responsible for ensuring the medications are always available and it is a medication error if a resident did not receive or at least offered the medications as ordered. During a review of the facility's policy and procedure (P&P), titled, Medication Monitoring and Management, last reviewed on 1/2025, the P&P indicated the interdisciplinary team reviews the resident's medication regimen. The P&P indicates in the event of a medication related error occurs, immediate action must be taken and the physician must be notified promptly. During a review of facility's policy and procedure (P&P), titled, Medication Administration-General Guidelines last reviewed on 1/15/2025, the P&P indicated, under administration Medications are administered in accordance with written orders of the prescriber.^^		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain medical records that were complete and accurately documented for two of 25 sampled residents (Residents 11 and 74) by: Failing to document Resident 11's blood pressure (the force your heart uses to send blood pumping through your body) prior to giving the resident metoprolol (a blood pressure lowering medication) on 9/9/2025 during medication review. This deficient practice resulted in inaccurate documentation in Resident 11's medical record and placed Resident 11 at risk for hypotension (low blood pressure). 2. Failing to ensure Resident 74's diagnosis of depression was reflected in the resident's list of diagnoses in the medical record. This failure resulted in Resident 74's medical record containing incomplete information which increased the potential of Resident 74 not receiving care for his diagnosis of depression. Findings: 1. During a review of Resident 11's admission Record, the admission Record indicated the facility initially admitted Resident 11 on 6/23/2021 and readmitted on [DATE] with diagnoses that included type 2 diabetes (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), hypertension (HTN-high blood pressure) and dizziness. During a review of Resident 11's History and Physical (H&P), dated 3/1/2025, the H&P indicated Resident 11 is not able to enter into a contract, including admission agreement due to fluctuating capacity to give informed consent regarding her medical/physical treatment. During a review of Resident 11's Minimum Data Set (MDS &ndash; an assessment and care screening tool) dated 10/21/2025, the MDS indicated Resident 11 had unclear speech, but was able to understand others and make herself understood. During a review of Resident 11's Physician's Order, the Physician's Order indicated an order dated 10/1/2025 for metoprolol tartrate 25 mg (milligram &ndash; unit of measurement) Give one tablet by mouth two times a day for HTN. Hold if SBP (systolic blood pressure &ndash; the first/top number) is below 110 or HR (heart rate) is below 60. During a review of Resident 11's Medication Administration Record (MAR) for 09/2025, the MAR indicated that on 9/9/2025, the box for the 5:00 pm dose of metoprolol had a check mark, however, the section where the blood pressure should have been documented was marked NA. During a review of the chart codes at the bottom of each MAR page, the chart codes indicated a check mark indicates medication was administered. During a concurrent interview and record review with the Assistant Director of Nursing, (ADON) on 11/19/2025 at 10:18 am, reviewed Resident 11's 09/2025 MAR. The ADON stated metoprolol has parameters that must be followed, and BP/HR must be taken prior to each administration. The ADON stated if the SBP is less that 110 and HR less than 60, metoprolol must be held. The ADON reviewed the entry for 9/9/2025 and stated the nurse should not have entered NA and entered a blood pressure. The ADON further stated NA stands for not available/applicable and if the resident did not want her blood pressure taken. The ADON further stated that the nurse should have held the medication to avoid Resident 11 from experiencing hypotension and dizziness. During a review of the facility provided policy and procedure (P&P) titled, General Documentation (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy last reviewed on 1/1/2025, the P&P indicated it is the policy of the facility to document the relevant findings in the clinical record specific to each individual resident's needs and conditions. The P&P further indicated staff members are to only chart what they see and hear related to a resident. 2. During a review of Resident 74's admission Record, the admission Record indicated the facility admitted the resident on 5/22/2024 with diagnoses including, but not limited to, chronic respiratory failure (a condition where the lungs cannot release enough oxygen into the blood) with hypoxia (an insufficient amount of oxygen in your body tissues) and end stage renal disease (ESRD, irreversible kidney failure). The diagnoses did not include depression. During a review of Resident 74's MDS, dated [DATE], the MDS indicated the resident had intact cognition (can think, learn, remember, use judgement, and make decisions). The MDS indicated Resident 74 reported having little interest or pleasure in doing things and felt down, depressed, or hopeless. The MDS further indicated Resident 74 required moderate or substantial assistance for most activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 74's psychiatric progress note, dated 9/23/2024, the psychiatric progress note indicated Resident 74 had an episode of major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) and would start Lexapro (an antidepressant medication) due to depression manifested by verbalization of sadness. During a review of Resident 74's Order Summary Report, the Order Summary Report indicated an active order dated 9/22/2025 to administer one Lexapro (medication used to treat depression) 10 milligram tablet at bedtime every night for depression manifested by persistently verbalizing sadness. During a review of Resident 74's care plan (a personalized document that outlines an individual's specific health needs, treatments, and goals to ensure they receive appropriate care and support) titled, The resident has a behavior of depression m/b (manifested by) persistently verbalizing sadness., dated 9/11/2024, the care plan indicated a goal to have decreased episodes of depression. During an interview on 11/20/2025 at 1:34 p.m. with the Director of Nursing (DON), the DON stated Resident 74's medical record should include the diagnosis of depression. The DON stated without including the depression diagnosis the staff will be lacking information about the resident which could lead to having an incomplete plan of care. During a review of the facility's policy and procedure (P&P) titled, General Documentation Policy, last reviewed on 1/15/2025, the P&P indicated it is the policy of the facility to document the relevant findings in the clinical record specific to each individual resident's needs and conditions.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain appropriate infection control practices for two of two sampled residents (Resident 2 and 34) when a work computer laptop was observed placed on top of a soiled linen hamper (a large, lidded container designated for dirty linen). This deficient practice had the potential to cause cross contamination (transfer of bacteria or other microorganisms from one place to another) and the spread of infection for residents, staff and visitors. Findings: a. During a review of Resident 2's admission Record, the admission Record indicated the facility originally admitted the resident on 5/22/2019 and re-admitted the resident on 11/12/2025, with diagnosis that included acute (sudden onset) and chronic (long term) respiratory failure (a condition where the lungs cannot release enough oxygen into the blood), end stage renal disease (ESRD, irreversible kidney failure) and dependence on renal dialysis (a medical treatment that removes waste and excess fluid from the blood when kidneys can no longer perform these functions). During a review of the Minimum Data Set (MDS - a resident assessment tool) dated 10/4/2025, the MDS indicated Resident 2's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were moderately impaired. The MDS indicated Patient 2 was dependent on staff for all activities of daily living (ADL - activities such as bathing, dressing, and toileting). b. During a review of Resident 34's admission Record, the admission Record indicated the facility originally admitted the resident on 4/12/2025 and re-admitted the resident on 6/24/2025, with diagnosis that included chronic respiratory failure with hypoxia (a medical condition where the body's tissues don't receive enough oxygen), ESRD, and dependence on renal dialysis. During a review of Resident 34's MDS, dated [DATE], the MDS indicated Resident 34 is in a persistent vegetative state (a chronic condition with absence of responsiveness and awareness due to overwhelming dysfunction of the brain) with no discernible consciousness (no evidence of awareness of self or environment). The MDS indicated Resident 34 was dependent on staff for all ADL. During a concurrent observation and interview on 11/17/2025 at 9:30 a.m., with the Hemodialysis Technician (HD Tech) in Resident 2 and 34's room, observed a computer laptop rested on top of the soiled linen hamper. The HD Tech stated the laptop is his, and he (HD Tech) placed it on top of the soiled linen hamper. During a concurrent observation and interview on 11/17/2025 at 9:49 a.m., with the Hemodialysis Registered Nurse (HDRN), the HDRN described what he (HDRN) observed in Resident 2 and 34's room. The HDRN stated the HD Tech's work laptop was observed resting on top of the soiled linen hamper. The HDRN stated that the computer laptop should not be placed on the soiled linen hamper and it should be kept in a clean area. The HDRN further explained placing the computer laptop on the soiled linen hamper is a risk for contamination which could result in spread of infections. The HDRN stated Residents 2 and 34 are at an increased risk for infection due to the presence of central venous catheters (CVC - a flexible plastic tube inserted into a large vein in the neck, chest or groin used for dialysis). During an interview on 11/19/2025 at 11:03 a.m., with the Quality Assurance Nurse (QAN), the QAN stated placing a computer laptop on the soiled linen hamper is not following infection control. The QAN stated the soiled linen hamper is considered contaminated or dirty surface and placing clean equipment such as a laptop on it results in contamination of the device. During an interview on 11/20/2025 at 10:55a.m., with the Infection Prevention Nurse (IPN), the IPN stated it is absolutely not acceptable to place a computer laptop on top of the soiled linen hamper which is considered dirty. The IPN stated unknown microorganisms may get transmitted from the soiled linen hamper to the computer laptop to the resident(s), causing infection that may lead to sepsis (a life-threatening blood infection) and potentially death. The IPN described Resident 2 and 34 as immunocompromised (having a weakened immune system, which reduces the body's ability to fight off infections and diseases). During a review of facility's policy and procedure (P&P) titled, Environmental Infection Control, last reviewed 1/2025, the P&P indicated, Topanga Terrace Rehabilitation & Subacute maintains a clean, (continued on next page)		

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Centers for Medicare & Medicaid Services

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sanitary, and safe environment by implementing environmental infection control practices designed to prevent pathogens from spreading among residents, staff, and visitors. Equipment must be: .Separate from soiled equipment.		

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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** Based on interview and record review, the facility failed to offer an updated 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 2). This deficient practice placed Resident 2 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 2's admission Record, the admission Record indicated the facility originally admitted the resident on 5/22/2019 and readmitted the resident on 11/12/2025 with diagnoses including, but not limited to, acute (sudden onset) and chronic (long term) respiratory failure (a condition where the lungs cannot release enough oxygen into the blood) with hypoxia (an insufficient amount of oxygen in your body tissues), end stage renal disease (ESRD, irreversible kidney failure), and type two diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 2's MDS, dated [DATE], the MDS indicated the resident's cognitive skills (relating to or involving the processes of thinking and reasoning) for daily decision making were severely impaired. The MDS indicated Resident 2 was dependent on staff for all activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a concurrent interview and record review on 11/18/2025 at 3:35 p.m., with the Infection Preventionist Nurse (IPN), reviewed Resident 2's Immunization Report. Resident 2's Immunization Report did not indicate Resident 2 received or refused an updated COVID-19 vaccine in 2024 or 2025. The IPN could not provide documentation that Resident 2 was offered an updated COVID-19 vaccine in 2024 or 2025. The IPN stated Resident 2 should have been offered an updated COVID-19 vaccine to prevent becoming infected with COVID-19. The IPN stated Resident 2 has risk factors for having complications from COVID-19 as she is on dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney[s] have failed) and has acute respiratory failure and congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling). During an interview on 11/20/2025 at 1:34 p.m., with the Director of Nursing (DON), the DON stated Resident 2 should have been offered an updated COVID-19 vaccination. The DON stated without the updated COVID-19 vaccine, Resident 2 is more likely to be infected with the virus, have debilitating symptoms from the virus, and could potentially spread it to other residents. During a review of the facility's policy and procedure (P&P) titled, COVID-19 Vaccination of Staff and Residents, last reviewed on 1/15/2025, the P&P indicated .the facility must educate and offer recommended vaccine doses as soon as recommendations are released by the CDC and doses are made available to the facility, for both residents and staff.		