STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056133	A. Building B. Wing	09/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Hills Health and Rehabilitation Center	7940 Topanga Canyon 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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 39550 Based on observation, interview, and record review, the facility failed to ensure a call light (a device used by a resident to signal his/her need for assistance from staff) was within a resident ' s reach while in bed for one of three sampled residents (Resident 2). This deficient practice had the potential to delay the provision of services and the resident ' s needs not being met. Findings: During a review of Resident 2 ' s Admission Record, the document indicated the facility admitted the resident on 9/28/2024 with diagnoses that included Parkinsonism (a disorder of the central nervous system [makes up of the brain and spinal cord] that affects movement, often including tremors [involuntary shaking or movement]), acquired absence of left upper limb below elbow, anxiety disorder (intense, excessive, and persistent worry and fear about everyday situations), morbid (severe) obesity, and heart failure (heart is not pumping as well as it should be. During a review of Resident 2 ' s Minimum Data Set (MDS- a standardized assessment and screening tool) dated 8/16/2024, the document indicated Resident 2 had moderately impaired cognitive (refers to mental activities including thinking, reasoning, understanding, learning, and remembering) skills for daily decision making. The MDS indicated Resident 2 required set up or clean up assistance with eating, required partial/moderate assistance with oral hygiene and personal hygiene, and dependent with toileting. During a review of Resident 2 ' s Care Plan (a written document that summarizes a resident ' s needs, goals, and care/treatment) titled, Activities of Daily Living (ADL- activities related to personal care)/self-care deficit, initiated on 11/21/2021, the document indicated an intervention to place call light within easy reach. During an observation on 9/30/2024 at 2:40 p.m., in Resident 2 ' s room, observed Resident 2 in bed and Resident 2 ' s call light on the floor and not within reach. (continued on next page)

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

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 9/30/2024 at 2:49 p.m., with Licensed Vocational Nurse 1 (LVN 1), observed Resident 2 in bed and Resident 2 ' s call light on the floor and not within reach. Observed LVN 1 place the call light within Resident 2 ' s reach and stated residents ' call light should always be within reach in case of an emergency, so the resident can call for assistance. During an interview on 9/30/2024 at 4:24 p.m., with the Director of Nursing (DON), the DON stated that residents ' call light should always be reachable at the bedside. The DON stated call lights should be easily accessible to the resident so when the resident needs help or assistance, he/she can have access to call staff. During a follow-up observation and concurrent interview on 9/30/2024 at 4:26 p.m., with the DON, in Resident 2 ' s room, observed Resident 2 in bed with their call light hanging off Resident 2 ' s bed. The DON stated that Resident 2 ' s call light was not within reach. Observed the DON place the call light within Resident 2 ' s reach and stated residents ' call light should always be within reach for the resident ' s safety. During a review of the facility ' s policy and procedure titled, Call Light System, Resident, reviewed 1/10/2024, the policy indicated residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized workstation. Each resident is provided with a means to call staff directly for assistance from his/her bed. Calls for assistance are answered as soon as possible, but no later than five (5) minutes.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39550 Based on interview and record review, the facility failed to implement the facility ' s policy on personal alarms by failing to check the functionality of a resident ' s bed pad alarm (a device that will sound if a resident moves) daily for one of three sampled residents (Resident 3). This deficient practice had the potential to place Resident 3 at risk for injuries and falls. Findings: During a review of Resident 3 ' s Admission Record, the document indicated the facility admitted the resident on 9/24/2024 with diagnoses that included Alzheimer ' s disease (a progressive disease that destroys memory and other important mental functions), unspecified osteoarthritis (occurs when the flexible, protective tissue at the ends of bones, called cartilage, wears down), unspecified fracture (break in bone) of T11-T12 vertebra (each of the series of small bones forming the backbone) subsequent encounter for fracture with routine healing, and multiple fractures of ribs, left side, subsequent encounter for fracture with routine healing. During a review of Resident 3 ' s History and Physical (H&P- a comprehensive assessment of a resident ' s medical history and current condition) progress note dated 9/25/2024, the document indicated Resident 3 does not have the capacity to understand and make decisions. During a review of Resident 3 ' s Fall Risk assessment dated [DATE] at 9:43 p.m., the document indicated Resident 3 was a high risk for fall. During a review of Resident 3 ' s Baseline Care Plan (a written document that summarizes a resident ' s needs, goals, and care/treatment) for safety/fall risk dated 9/24/2024, the document indicated Resident 3 had a history of fall and fall related injury (fractures). An intervention included to utilize safety device as ordered. During a review of Resident 3 ' s Order Summary Report, the document indicated an order for bed pad alarm secondary to unassisted transfer for safety awareness, ordered 9/29/2024. During an observation on 9/30/2024 at 3:01 p.m., in Resident 3 ' s room, observed Resident 3 sleeping in bed with a bed pad alarm in place. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 9/30/2024 at 5:13 p.m., with the Director of Nursing (DON), reviewed Resident 3 ' s progress notes dated 9/29/2024 to 9/30/2024 and Medication Administration Record (MAR, a report detailing the drugs administered to a resident by the licensed nurses) and Treatment Administration Record (TAR, a legal document indicating the dates a treatment was conducted for a resident) for 9/2024. The DON stated that there is no documented evidence related to monitoring the functionality of Resident 3 ' s bed pad alarm. When asked about the importance of ensuring the bed pad alarms functionality, the DON stated that it is important to ensure the bed pad alarm is functional so that the facility staff know that the device is serving its purpose, which is to alert staff if the resident is about to get out of bed unassisted and so we can assist the resident to avoid any accidents. During a review of the facility ' s policy and procedure titled, Personal Alarm, review date 1/10/2024, the policy indicated the facility will use, as indicated, a sensor pad that conveniently sounds as audible alarm when the sensor detects a patient (resident) rising out of the bed/wheelchair reminding the resident to return to a safe position while alerting staff to a potential fall. Check alarm system every day for proper functioning. Nursing will monitor proper functioning and positioning of personal alarm. During a review of the facility-provided manufacture ' s guidelines titled, Bed Sensormat Pad Model 92010, the document indicated under testing the system: 1. Plug the pad into the alarm monitor. 2. Apply pressure to the pad, and then remove pressure to make sure local, audible alarm is functioning properly.