Printed: 03/27/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/24/2025
NAME OF PROVIDER OR SUPPLIER West Hills Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 43636 Based on interview and record review the facility failed to ensure physician orders were written accurately for one of three sampled residents (Resident 1) by failing to clarify with the physician Resident 1's potassium chloride (medication used in the management and treatment of low potassium) order for Resident 1 who was unable to self-administer medications. This deficient practice placed Resident 1 at risk for receiving an incorrect dosage of potassium, potentially leading to health complications. Findings: During a review of Resident 1's Admission Record dated 10/28/2020, the Admission Record indicated the facility admitted the resident on 10/28/2020 with diagnoses included cerebral palsy (group of movement disorders that can cause problems with posture, manner of walking (gait), muscle tone, and coordination), altered mental status (a disruption in how your brain works that causes a change in behavior). During a review of Resident 1's History and Physical (H&P- a formal assessment by a healthcare provider that involves a resident interview, physical exam, and documentation of findings) dated 10/29/2020, the H&P indicated Resident 1 does not have the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 11/3/2020, the MDS indicated Resident 1's cognition (ability to think and make decisions) was not intact. The MDS further indicated that Resident 1 required total dependence on staff for assistance with activities of daily living (include bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating). During a review of Resident 1's physician's orders dated 12/17/2020, the orders indicated an order for potassium chloride, give 20 milliequivalent (mEq, a unit of measurement) via gastrostomy tube (G-tube, a tube that is places directly into the stomach through an abdominal wall for administration of food, fluids, and medications). During an interview on 1/24/2025 at 11:30 p.m., with the Director of Nursing (DON), the DON confirmed by stating that Resident 1 would not have been able to self-administer medication, and the nursing staff should have clarified the order with the physician at the time of the order. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Verbal Orders, with an approved date of 1/8/2025, the policy indicated verbal orders will always be based on verbal exchange with the prescribing practitioner or on approved written protocols .The individual receiving the verbal order will: a. Read the order back to the practitioner to ensure that the information is clearly understood and correctly transcribed.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 43636 Based on interview and record review, the facility failed to clarify with the physician a resident's gastrostomy tube (G-tube-a tube that is places directly into the stomach through an abdominal wall for administration of food, fluids, and medications) feeding order for one of three samples residents (Resident 1). Resident 1's G-tube feeding order did not indicate how many cubic centimeters (CC-unit of measure in volume) and calories (a measurement of the energy content of food) were provided to Resident 1 each day. This deficient practice had the potential to result in Resident 1 having unplanned weight loss or gain and altered nutritional status that can lead to health complications. Findings: During a review of Resident 1's Admission Record dated 10/28/2020, the Admission Record indicated the facility admitted the resident on 10/28/2020 with diagnoses included cerebral palsy (group of movement disorders that can cause problems with posture, manner of walking (gait), muscle tone, and coordination), altered mental status (a disruption in how your brain works that causes a change in behavior). During a review of Resident 1's History and Physical (H&P- a formal assessment by a healthcare provider that involves a resident interview, physical exam, and documentation of findings) dated 10/29/2020, the H&P indicated Resident 1 does not have the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 11/3/2020, the MDS indicated Resident 1's cognition (ability to think and make decisions) was not intact. The MDS further indicated that Resident 1 required total dependence on staff for assistance with activities of daily living (include bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating). During a review of Resident 1's physician order dated 12/17/2020, the order indicated the following order: -Enteral order for Jevity 1.5 at 65 cc per hour for hours via pump to provide (blank) CC/ (blank) Kcal) per day. Turn pump on at 12p.m. and turn off at 8 a.m. (or until dose is completed) During an interview on 1/24/2025 at 11:30 p.m., with the Director of Nursing (DON), the DON stated that when obtaining a feeding order for a G-tube feeding the nursing staff should confirm with the physician the amount of CC that should be infused within a 24-hour period and the amount of caloric intake in a 24-hour period. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Enteral Nutrition, with revised date of 11/2018, the P&P indicated adequate nutritional support through enteral nutrition is provided to residents as ordered. The dietician, with the input from the provider and nurse will estimate calorie, protein, nutrient and fluid needs; determines whether the resident's current intake is adequate to meet his or her nutritional needs. The nurse confirms that the orders for enteral nutrition are complete.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. 43636 Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1), who has a diagnosis of cerebral palsy (group of movement disorders that can cause problems with posture, manner of walking (gait), muscle tone, and coordination) received specialized rehabilitative services (special health care services that help a person regain physical, mental, and/or cognitive [thinking and learning] abilities that have been lost or impaired as a result of disease, injury, or treatment). This deficient practice had the potential for Resident 1's to have a decrease in functional mobility, quality of life and higher risk for further decline. Findings: During a review of Resident 1's Admission Record dated 10/28/2020, the Admission Record indicated the facility admitted the resident on 10/28/2020 with diagnoses including cerebral palsy, and altered mental status (a disruption in how your brain works that causes a change in behavior), and urinary tract infection (an infection in any part of your urinary system During a review of Resident 1's History and Physical (H&P- a formal assessment by a healthcare provider that involves a resident interview, physical exam, and documentation of findings) dated 10/29/2020 indicated, the H&P indicated Resident 1 does not have the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 11/3/2020, the MDS indicated Resident 1's cognition (ability to think and make decisions) was not intact. The MDS further indicated that Resident 1 required total dependence on staff for assistance with activities of daily living (include bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating). Resident 1's diagnoses included cerebral palsy. During a review of Resident 1's physician order dated 10/28/2020, the physician order indicated an order for physical therapy, occupational therapy and speech therapy evaluation and treatment. During an interview on 1/23/2025 at 11:30 a.m., with the Director of Rehabilitation (DOR), the DOR stated that when a resident is admitted with a history of intellectual disabilities (a term used when a person has certain limitations in cognitive functioning and skills, including conceptual, social and practical skills, such as language, social and self-care skills) including cerebral palsy, the rehabilitation staff will speak to the responsible party or the previous facility from where the resident came from and discuss what type of treatment the resident was previously receiving and what the resident's functional level was so the facility can continue the care that was being provided to the resident previously. The DOR stated that she (DOR) she is not aware if the previous rehabilitation staff spoke with the responsible party or the previous facility where Resident 1 was living prior to being admitted to this facility. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/23/2025 at 2:00 p.m., with the Director of Nursing (DON), the DON stated that when admitting a resident with a a history of intellectual disabilities, they will speak to the responsible party or the previous facility to determine the resident's functional level and prior therapy the resident was receiving. During a review of the facility's policy and procedure (P&P) titled, Specialized Rehabilitative Services, with an approved date on 1/8/2025, the policy and procedure indicated the facility will provide rehabilitative services to resident as indicated by the MDS .In addition to rehabilitative nursing care, the facility provides specialized rehabilitative services by qualified professional personnel.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 43636 Based on interview and record review, the facility staff failed to ensure one of three sampled residents (Resident 1) had accurate nursing assessments completed daily and accurately documented regarding Resident 1's activities of daily living (ADLs-routine/tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). This deficient practice had the potential to negativity affect the resident's quality of life, quality of care, and the quality of services provided. Findings: During a review of Resident 1's Admission Record dated 10/28/2020, the Admission Record indicated the facility admitted the resident on 10/28/2020 with diagnoses including cerebral palsy (group of movement disorders that can cause problems with posture, manner of walking (gait), muscle tone, and coordination), altered mental status (a disruption in how your brain works that causes a change in behavior), urinary tract infection (UTI-an infection in any part of your urinary system), heart failure (a condition in which the heart doesn't pump blood as well as it should), epilepsy (happens as a result of abnormal electrical brain activity, also known as a seizure, kind of like an electrical storm inside your head), quadriplegia (a condition where all four limbs experience loss of movement), and anxiety disorder (a feeling of fear, dread, and uneasiness). During a review of Resident 1's History and Physical (H&P- a formal assessment by a healthcare provider that involves a resident interview, physical exam, and documentation of findings) dated 10/29/2020, the H&P indicated Resident 1 does not have the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 11/3/2020, the MDS indicated Resident 1's cognition (ability to think and make decisions) was not intact. The MDS further indicated that Resident 1 required total dependence on staff for assistance with ADLs. During a review of Resident 1's Medication Administration Record (MAR, a report detailing the drugs administered to a resident by the licensed nurse in the facility) dated 11/2020, the MAR indicated Resident 1 was being administered meropenem (medication used to treat an infection) 500 milligrams (mg-a unit of measurement) every 12 hours with an end date of 11/2/2020 for a urinary tract infection. During a review of Resident 1's daily licensed nurse records dated 11/8/2020 through 12/13/2020, the daily licensed nurse records indicated Resident 1 was receiving meropenem 500 mg every six (6) hours for a urinary tract infection. During a review of Resident 1's physician order dated 12/13/2020, the order indicated to transfer Resident 1 to the General Acute Care Hospital (GACH) for further evaluation due to vomiting. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 1's ADL logs dated 12/2020, the ADL logs indicated on 12/14/2020 and 12/15/2020 Resident 1 required assistance with bed mobility, dressing, personal hygiene, toilet use and walking. During a review of Resident 1's physician orders dated 12/18/2020, the order indicated to admit Resident 1 back to the facility. During a concurrent interview and record review on 1/24/2025 at 11:30 a.m., with the Director of Nursing (DON), reviewed Resident 1's daily licensed nurse records dated 11/8/2020 through 12/13/2020, MAR dated 11/2020, and ADL log dated 12/2020. The DON stated that licensed nursing staff should not have documented that Resident 1 was receiving meropenem after the resident had finished the antibiotic (meropenem). The DON stated the Certified Nursing Assistants (CNAs) should not have documented Resident 1's activities of daily living on 12/14/2020-12/15/2020 because the resident was not in the facility. The DON stated staff complete accurate assessments and documentation for each resident. During a review of the facility's policy and procedure (P&P) titled, Charting and Documentations, with an approval date of 1/8/2025, the policy indicated all services provided to the resident, progress toward the care plan goals, or any changes, in the resident's medical, physical functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care .Documentation in the medical records may be electronic, manual or a combination .The following information is to be documented in the residents' medical records include .Medications administered .Progress toward or changes in the care plan goals and objectives .Documentation in the medical records will be objective, complete and accurate.