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	03/20/2025

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

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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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39550 Based on interview and record review, the facility failed to ensure a resident's notice of proposed transfer and discharge was provided to the resident at least 30 days prior to discharge or as soon as practicable for two of three sampled residents (Resident 2 and Resident 3). This deficient practice placed Resident 2 and Resident 3 at increased risk of an inappropriate discharge and had the potential to deny the resident of their right to file an appeal to the appropriate agency. Findings: a. During a review of Resident 2's Admission Record, the Admission Record indicated the facility admitted Resident 2 on 2/14/2025 with diagnoses that included encephalopathy (a broad term for any brain disease that alters brain function or structure), memory deficit following nontraumatic intra cerebral hemorrhage (emergency condition on which a ruptured blood vessel causes bleeding inside the brain, and legal blindness. During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool) dated 3/4/2025, the MDS indicated Resident 2's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the sense) was severely impaired. The MDS indicated Resident 2 required supervision or touching assistance from staff with oral hygiene, and partial/moderate assistance with toileting hygiene and personal hygiene. During a review of Resident 2's Notice of Medicare Non-Coverage (NOMNC- form used by Medicare [federal health insurance program] providers to inform beneficiaries [a person or entity that receives a benefit from something] that their Medicare-covered services are ending) dated 2/26/2025, the NOMNC indicated Medicare coverage of your current service will end on 3/1/2025. Confirmation of notice by telephone, dated 2/26/2025 at 2:00 p.m. During a review of Resident 2's physician order dated 2/28/2025 at 5:07 p.m., the physician order indicated an order for last covered date (LCD- final date on which services or benefits are provided) 3/1/2025. Discharge home versus custodial care 3/2/2025. (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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2's document titled, Notice of Proposed Transfer and Discharge, dated 3/4/2025 at 3:52 p.m., the document indicated Resident 2 was notified of the proposed discharge on 3/4/2025 (four days after the facility received the discharge order from the physician). During a concurrent interview and record review on 3/21/2025 at 1:42 p.m., with the Director of Nursing (DON), reviewed Resident 2's NOMNC dated 2/26/2025, Resident 2's physician's order, and Resident 2's Notice of Proposed Transfer and discharge date d 3/4/2025. The DON stated that Resident 2 received a NOMNC on 2/26/2025 to inform Resident 2 that Resident 2's LCD of insurance was on 3/1/2025. The DON reviewed Resident 2's physician order and stated that Resident 2 had a discharge order dated 2/28/2025 for discharge on 3/2/2025. The DON continued to state that Resident 2's son appealed Resident 2's discharge, however, did not win the appeal. The DON reviewed Resident 2's Notice of Proposed Transfer and discharge date d 3/4/2025 and stated that Resident 2 received the Notice of Proposed Transfer and Discharge notification the day of Resident 2's discharge on 3/4/2025. The DON continued to state that the facility should have given Resident 2 and her representative the Notice of Proposed Transfer and Discharge notification on 2/26/2025. b. During a review of Resident 3's Admission Record, the Admission Record indicated the facility admitted Resident 3 on 2/14/2025 with diagnoses that included transient cerebral ischemic attack (a temporary interruption of blood flow to the brain), cellulitis (a bacterial infection of your skin and the tissues beneath your skin) of left lower limb, and sepsis (a life-threatening complication of an infection). During a review of Resident 3's MDS dated [DATE], the MDS indicated Resident 3's cognition was intact. The MDS indicated Resident 3 required partial/moderate assistance with oral hygiene, toileting hygiene and personal hygiene. During a review of Resident 3's NOMNC dated 2/28/2025, the NOMNC indicted Medicare coverage of current service will end on 3/2/2025. Discharge on 3/3/2025. Signed by Resident 3 on 2/28/2025. During a review of Resident 3's physician order dated 2/28/2025 at 4:52 p.m., the physician order indicated an order for last covered date 3/2/2025. Discharge home, 3/3/2025. During a review of Resident 3's document titled, Notice of Proposed Transfer and Discharge, dated 3/3/2025 at 12:19 p.m., the document indicated Resident 3 was notified of the proposed discharge on 3/3/2025 (three days after the facility received the discharge order from the physician). (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 3/21/2025 at 1:49 p.m., with the DON, reviewed Resident 3's NOMNC dated 3/2/2025, Resident 3's physician's orders, and Resident 3's Notice of Proposed Transfer and discharge date d 3/3/2025. The DON stated that Resident 3 received a NOMNC on 2/28/2025 to inform Resident 3's LCD of insurance was on 3/2/2025. The DON reviewed Resident 3's physician order and stated that Resident 3 had a discharge order on 2/28/2025 for discharge on 3/3/2025. The DON reviewed Resident 3's Notice of Proposed Transfer and discharge date d 3/3/2025 and stated that Resident 3 received the Notice of Proposed Transfer and Discharge notification the day of Resident 3's discharge on 3/3/2025. The DON continued to state that the facility should have given Resident 3 the Notice of Proposed Transfer and Discharge notification on 2/28/2025. The DON continued to state that the Notice of Proposed Transfer and Discharge notification should be given before discharge so that residents have time to appeal the discharge with the facility. During a review of the facility's policy and procedure titled, Transfer or Discharge Notice, review date 1/8/2025, the policy indicated residents and/or representatives are notified in writing, and in a language and format they understand, at least thirty (30) days prior to transfer or discharge. Under the following circumstances the notice is given as soon as it is practicable but before the transfer or discharge: c. The resident's health improves significantly to allow a more immediate transfer or discharge.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 39550 Based on interview and record review, the facility failed to implement the facility's policy on urinary catheter (a flexible tube inserted into the bladder and left in place to continuously drain urine) care for one of three sampled residents (Resident 1), by failing to provide documented evidence that urinary catheter care was provided to Resident 1 and failing to provide documented evidence of staff monitoring Resident 1's urinary output. This deficient practice had the potential for Resident 1 not to attain their highest functional level. Findings: During a review of Resident 1's Admission Record, the Admission Record indicated the facility admitted the resident on 3/1/2025 with diagnoses that included malignant neoplasm of bladder (bladder [organ that stores urine] cancer), retention of urine (inability to completely empty the bladder), and encounter for surgical aftercare following surgery on the genitourinary system (organs and structures involved in both reproduction and urination). During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 3/3/2025, the MDS indicated that Resident 1 required partial/moderate assistance with oral hygiene and toileting hygiene. During a concurrent interview and record review on 3/20/2025 at 1:28 p.m., with the Director of Nursing (DON), reviewed Resident 1's Treatment Administration Record (TAR, a legal document indicating the dates a treatment was conducted for a resident) for 3/2025 and progress notes from 3/1/2025 to 3/3/2025. The DON stated when a resident has a urinary catheter, catheter care should be provided daily and licensed nurses are to monitor urinary output by documenting color, odor, and consistency of the urine output. The DON stated that there is no documented evidence that urinary catheter care was provided to Resident 1 and no documented evidence that staff were monitoring color, odor, and consistency of urine output. The DON stated that because of Resident 1's cancer diagnosis, the facility should be monitoring and documenting Resident 1's urinary output to ensure adequate output. The DON stated that urinary catheter care is important to help avoid infections. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure titled, Catheter Care, Urinary, reviewed1/8/2025, the policy indicated the purpose of this procedure is to prevent urinary catheter associated complications, including urinary tract infections (UTI, an infection in any part of the urinary system). Under documentation: The following information should be recorded in the resident's medical record: 1. The date and time that catheter care was given; 2. The name and title of the individual(s) giving catheter care; 3. Character of urine such as color (straw-colored, dark, or red), clarity (cloudy, solid particles, or blood), and odor; 4. Any problems noted at the catheter-urethral junction (the point where a urinary catheter is inserted into the urethra [tube through which urine leaves the body]) during perineal care (washing the genitals and anal area) such as drainage, redness, bleeding, irritation, crusting, or pain; 5. Any problems or complaints made by the resident related to the procedure; 6. If the resident refused the procedure, the reason(s) why and the interventions taken; 7. The signature and title of the person recording the data. a

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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** 39550 Based on interview and record review, the facility failed to ensure a resident's attending physician documented a resident's History and Physical (H&P- a formal assessment by a healthcare provider that involves a resident interview, physical exam, and documentation of findings) within 72 hours following admission for two of three sampled residents (Resident 2 and Resident 3). This deficient practice had the potential for inconsistent care coordination due to incomplete medical records for Resident 2 and Resident 3. Findings: a. During a review of Resident 2's Admission Record, the Admission Record indicated the facility admitted Resident 2 on 2/14/2025 with diagnoses that included encephalopathy (a broad term for any brain disease that alters brain function or structure), memory deficit following nontraumatic intra cerebral hemorrhage (emergency condition on which a ruptured blood vessel causes bleeding inside the brain, and legal blindness. During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool) dated 3/4/2025, the MDS indicated Resident 2's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the sense) was severely impaired. The MDS indicated Resident 2 required supervision or touching assistance from staff with oral hygiene, and partial/moderate assistance with toileting hygiene and personal hygiene. During a concurrent interview and record review on 3/21/2025 at 11:47 a.m., with the MDS Nurse (MDSN), reviewed Resident 2's medical records in regards to H&Ps. The MDSN stated that there was no documented evidence of Resident 2's admission H&P. During a concurrent interview and record review on 3/21/2025 at 11:55 a.m., with the Medical Records Director (MRD), reviewed Resident 2's electronic and physical chart. The MRD stated that H&Ps from Resident 2's specific insurance group are sent to the facility via fax two times a week. The MRD stated that he (MRD) does not have access to residents' medical records from the specific insurance group's electronic medical records system and only receives medical records via fax to the MRD. The MRD was unable to find documented evidence of Resident 2's admission H&P. The MRD further stated that resident's H&Ps should be done within three days of admission. During a concurrent interview and record review on 3/21/2025 at 1:35 p.m., with the Director of Nursing (DON), reviewed Resident 2's medical records in regards to H&Ps. The DON stated that an admission H&P should be done and documented by the resident's attending physician within 72 hours of admission. The DON stated for Resident 2's insurance group, the residents' H&Ps are faxed to the facility. The DON reviewed Resident 2's medical records and stated that there was no documented evidence of Resident 2's admission H&P. The DON further stated that an admission H&P is important because it is a baseline assessment by the facility's physician and it is a document where the physician will document their plan of care and the facility will be able to review residents' treatment plan and medication treatment plan. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. During a review of Resident 3's Admission Record, the Admission Record indicated the facility admitted Resident 3 on 2/14/2025 with diagnoses that included transient cerebral ischemic attack (a temporary interruption of blood flow to the brain), cellulitis (a bacterial infection of your skin and the tissues beneath your skin) of left lower limb, and sepsis (a life-threatening complication of an infection). During a review of Resident 3's MDS dated [DATE], the MDS indicated Resident 3's cognition was intact. The MDS indicated Resident 3 required partial/moderate assistance with oral hygiene, toileting hygiene and personal hygiene. During a concurrent interview and record review on 3/21/2024 at 11:47 a.m., with MDSN, reviewed Resident 3's medical records in regards to H&Ps. The MDSN stated that there was no documented evidence of Resident 3's admission H&P. During a concurrent interview and record review on 3/21/2025 at 1:39 p.m., with the DON, reviewed Resident 3's medical records in regards to H&Ps. The DON stated that there was no documented evidence of Resident 3's admission H&P. During a review of the facility's policy and procedure titled, Physician Documentation, reviewed date 1/8/2025, the policy indicated a current history and physical shall be provided by the attending physician within 72 hours following admission. It is not appropriate for the physician to make reference to the acute hospital's record without updating the record to reflect the resident's current condition and diagnosis. During a review of the facility's policy and procedure titled, Charting and Documentation, reviewed date 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.