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	03/26/2025

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

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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42275 Based on interview and record review, the facility failed to accurately complete a dietary communication slip including food allergy information (refers to details about the resident's food allergies [a condition that causes illness when someone eats certain foods or touches or breathes in certain substances]) for one of five sampled residents (Resident 2) upon re-admission to the facility on [DATE] and prior to meal service. This deficient practice had the potential to place the resident at increased risk of being served with food containing food allergens (a substance that causes an allergic reaction) and had the potential to result in a life-threatening condition such as anaphylactic shock (severe allergic reaction including closure of airways). Findings: During a review of Resident 2 ' s Admission Record, the Admission Record indicated the facility readmitted Resident on 3/25/2025 with diagnoses that included malnutrition (lack of proper nutrition), atrial fibrillation (irregular and very rapid heart rhythm) and parkinson ' s disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination). During a review of Resident 2 ' s General Acute Care Hospital (GACH 1) Discharge Summary, under the Skilled Nursing Facility (SNF) Admission Orders dated 3/25/2025 timed at 11:36 a.m., indicated the following allergies including allergens and reactions to allergens: - Dairy Foods: causes irregular heartbeat - Eggplants, peppers, white potatoes and tomatoes causesjoint (the part of the body where two or more bones meet to allow movement) pain - Mint - herb: reaction unknown (continued on next page)

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

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2 ' s untitled handwritten diet communication slip dated 3/26/2025, indicated a new admission diet order of Regular (a type of diet wherein no specific modifications are made to the texture or consistency of foods), No Added Salt (NAS- a dietary restriction that limits the intake of sodium [a mineral found in salt]), thin (refers to liquids that are watery and easy to drink, like water, juice, tea, or milk). Resident 2 ' s untitled handwritten diet communication slip dated 3/26/2025 did not indicate Resident 2 ' s allergies. During a concurrent interview and record review with the Director of Nursing (DON) and the DSS on 3/26/2025 at 2:25 p.m., the DON and the DSS reviewed Resident 2 ' s untitled handwritten diet communication slip dated 3/26/2025. The DON stated that Resident 2 ' s food allergy information had been entered in the electronic health record (EHR - a digital record of a resident's health information, including demographics, medical history, medications, allergies, immunizations, lab results, and more) when Resident 2 was admitted last evening (3/25/2025). The DSS then stated that the nursing staff should have indicated Resident 2 ' s food allergies in the diet communication slip upon Resident 2 ' s re-admission and provide the completed diet communication slip to the dietary staff. The DSS stated that the dietary staff did not have the EHR access except the DSS, so, the dietary staff would follow the diet communication slip written by the nursing staff until the DSS confirms. The DSS further stated that the dietary staff provided Resident 2 ' s breakfast on the morning of 3/26/2025 before checking Resident 2 ' s food allergies. During a concurrent interview and record review on 3/26/2025 at 4:18 p.m., with Registered Nurse 1 (RN 1), RN 2, RN 3, and DON, Resident 2 ' s untitled handwritten diet communication slip dated 3/26/2025 was reviewed. RN 2 stated that she (RN 2) entered Resident 2 ' s diet order and food allergy information in the EHR when Resident 2 was readmitted to the facility last evening (3/25/2025). RN 2 further stated that RN 2 did not complete a diet communication slip because the kitchen was already closed. RN 3 confirmed it was his (RN 3) handwriting on Resident 2 ' s untitled handwritten diet communication slip dated 3/26/2025. RN 3 stated he (RN 3) did not include Resident 2 ' s food allergies information because the allergy information was already entered in the EHR system. The DON stated that, it was the admitting nurse ' s responsibility to complete a diet communication slip including a list of resident ' s food allergies regardless of the resident ' s arrival time to the facility. The DON stated that the dietary communication slip serves as a tool to inform the dietary staff a resident ' s known food allergy information before preparing the meal. During a review of the facility ' s policy and procedure (P&P), titled Food Allergies and Intolerances, last reviewed on 1/8/2025, the P&P indicated, Resident with food allergies and/or intolerances are identified upon admission and offered food substitutions of similar appeal and nutritional value. Steps are taken to prevent resident exposure the allergen(s) Severe food allergies are noted on the face of the chart (in the form of a sticker or permanent marking indicating Severe Food Allergy: (name of food) and communicated in writing directly to the dietician and the director of food and nutrition services During a review of the facility ' s P&P, titled Diet Orders, last reviewed on 1/8/2025, the P&P indicated, Upon admission, Nursing will transcribe the diet order as it is written by the physician on the diet order communication form. Forms are sent to the Dietary Department prior to meal service The resident ' s name, diet order, food likes and dislikes, allergies will be noted on the resident ' s Profile Card and tray card for staff reference.

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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. 42275 Based on observation, interview, and record review, the facility failed to implement infection control practices by failing to ensure a resident ' s bed controller was cleaned and disinfected to prevent the spread of germs and infections for one of five sampled residents (Resident 3). This deficient practice had the potential to result in the spread of germs placing residents, staff, and visitors at risk to be infected. Findings: During a review of Resident 3 ' s Admission Record, the Admission Record indicated the facility admitted the resident on 3/12/2025 with diagnoses that included right foot fracture (broken bone). During a review of Resident 3 ' s Minimum Data Set (MDS - a resident assessment tool) dated 3/18/2025, the MDS indicated the resident ' s cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was intact. The MDS further indicated that the resident needed maximal assistance from staff with toileting hygiene and upper body dressing, needed moderate assistance with bed mobility (movement), and Resident 3 was dependent on staff with transfer. During a concurrent observation and interview on 3/26/2025 at 11:05 a.m., in Resident 3 ' s room, observed that Resident 3 was lying in bed, and Resident 3 ' s bed controller was wrapped with a plastic bag. Resident 3 stated that Resident 3 wrapped the bed controller with a plastic bag because it was dirty. Resident 3 stated Resident 3 was telling staff to clean the bed controller thoroughly because it was dirty, but staff never cleaned it, so Resident 3 wrapped the bed controller with the plastic bag. During a concurrent observation and interview on 3/26/2025 at 11:10 a.m., with the Infection Control Preventionist (ICP) in Resident 3 ' s room, the ICP unwrapped Resident 3 ' s bed controller covered with the plastic bag and observed that it had buttons with icons for adjusting the head, foot, and bed high/low, and the bed controller was visibly dirty with grime around the buttons and casing. The ICP stated that Resident 3 ' s bed controller needed to be cleaned and stated it was dirty and filled with some unknown particles around the buttons. The ICP stated the ICP needed to call housekeeping (HK) staff to clean and disinfect the bed controller right away. During a concurrent observation and interview on 3/26/2025 at 11:38 a.m., with HK 1 and Housekeeping Supervisor (HKS), observed Resident 3 ' s bed controller. HK 1 stated that housekeeping cleaned Resident 3 ' s bed and bed frame on that morning (3/26/2025) at around 9 a.m. HK 1 stated HK 1 observed that Resident 3 ' s bed controller was wrapped with a plastic bag, so HK 1 did not clean it because HK 1 thought that it was something special and afraid to open it. When HK 1 was asked when Resident 3 ' s bed controller was covered with the plastic bag lastly, HK 1 stated that HK 1 noted that Resident 3 ' s bed controller was covered with the plastic bag when HK 1 worked last Thursday (3/20/2025) and that day (3/26/2025). The HKS stated that HK 1 should report to the HKS or nursing staff if HK 1 did not know what to do or afraid of touching some equipment to clean. The HKS stated the bed controller should be cleaned and disinfected daily at a minimum and as needed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/26/2025 at 6:06 p.m., with the Director of Nursing (DON), the DON stated that the residents ' bed controllers should be cleaned daily and as needed, otherwise the germs could be spread and against the infection control program. During a review of the facility ' s policy and procedure (P&P) titled, Infection Control, last reviewed on 1/8/2025, the policy indicated, The facility infection control policies and practices are intended to facilitate a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections. During a review of the facility ' s P&P titled, Cleaning and Disinfecting Residents ' Rooms, last reviewed on 1/8/2025, the policy indicated, Housekeeping surfaces (e.g., floors, tabletops) will be cleaned on a regular basis, when spills occur, and when these surfaces are visibly soiled. Environmental surfaces will be disinfected (or cleaned) on a regular basis and when surfaces are visibly soiled.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 42275 Based on observation, interview, and record review, the facility failed to provide a safe and comfortable environment by failing to: 1. Ensure that the facility staff did not leave an unlabeled drinking cup that contained soap in a resident ' s room for one out of six sampled residents (Resident 1). 2. Ensure a drinking cup unlabeled that contained hair and body shampoo (H&BS) was not left in a utility room (UR - a dedicated area for tasks that involve cleaning, disinfecting, and storing items used in resident care, such as bedpans, urinals, and soap/shampoo/mouthwash). These deficient practices had the potential to place residents, staff, and visitors at risk for unsafe and/or uncomfortable environment. Findings: 1. During a review of Resident 1 ' s Admission Record, the Admission Record indicated the facility admitted the resident on 3/12/2025 with diagnoses that included pelvis (the bony structure inside hips, buttocks and pubic region) fracture (broken bone). During a review of Resident 1 ' s Minimum Data Set (MDS - a resident assessment tool) dated 3/18/2025, the MDS indicated the resident ' s cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was moderately impaired. The MDS further indicated that the resident needed maximal assistance from staff with toileting hygiene and upper/lower body dressing, bed mobility (movement), and transfer, and needed supervision or touching assistance with oral hygiene. During a review of the document titled, Concern Record, reported on 3/19/2025, the Concern Record indicated that the Certified Nursing Assistant (CNA 1) assigned for the resident (Resident 1) witnessed when Resident 1 grabbed the cup of shampoo and gargled it. CNA 1 immediately advised to rinse Resident 1 ' s mouth with water to dilute any shampoo residue. CNA 1 said that the cup of shampoo was besides the mouthwash and Resident 1 mistakenly thought that it was a mouthwash because of the same color. CNA 1 saved the cup of shampoo and showed that saved cup to Resident 1 and confirmed that was the one Resident 1 gargled. During a phone interview on 3/26/2025 at 4:40 p.m., with CNA 1, CNA 1 stated CNA 1 was able to recall the incident that CNA 1 saw Resident 1 was holding the drinking cup that contained a blue color of soap which was the same color of mouthwash in Resident 1 ' s bathroom. CNA 1 stated CNA 1 did not see that cup while CNA 1 set up for Resident 1 ' s oral hygiene. CNA 1 stated CNA 1 asked what Resident 1 did with the soap in a cup and stated Resident 1 stated that Resident 1 gargled it. CNA 1 stated CNA 1 told Resident 1 to rinse the resident ' s mouth thoroughly, then reported to the charge nurse immediately. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 3/26/2025 at 5:15 p.m., with the Director of Staff Development (DSD), reviewed the Concern Record reported on 3/19/2025. The DSD stated that the investigation was initiated when the facility received the incident report, and provided the in-services (educational sessions for staff to enhance their knowledge and skills, ensuring they deliver high-quality care and meet regulatory requirements) not to use drinking cups with soap/shampoo and discard the used cups safely to avoid confusion with mouthwash. 2. During an observation on 3/26/2025 at 9 a.m., with CNA 2 in the utility room located near nurse station 1, observed a blue color liquid in a plastic drinking cup placed next to the sink without a label or any information on the cup. When CNA 2 was asked to describe what CNA 2 observed, CNA 2 stated that the color of mouthwash was the same blue color as the fluid in the cup, but CNA 2 could not tell what it was because there was no information written on the cup. CNA 2 smelled the cup and stated that it looked like soap, but CNA 2 could not tell for sure. CNA 2 stated that staff should not keep any leftover mouthwash or soap in a drinking cup for a safety reason. During a concurrent observation and interview on 3/26/2025 at 9:42 a.m., with the Assistant Director of Staff Development (ADSD) and the Housekeeping Supervisor (HKS) in the hallway of housekeeping storage, the HKS got the original bottle of H&BS from the housekeeping storage and compared the liquid in the drinking cup found in the utility room next to sink. The HKS stated that the color was the same blue color of the mouthwash, but the texture of H&BS was different, and H&BS was thicker than the mouthwash. The HKS stated that the cup found in the utility room that contained blue color of liquid was the H&BS. During a concurrent interview and record review on 3/26/2025 at 6:03 p.m., with the Director of Nursing (DON), reviewed the photo of the drinking cup that contained the blue color of soap that Resident 1 gargled. The DON stated that staff saved the photo and stated that the cup was not labeled. The DON compared the photo and the cup with the H&BS found on that day (3/26/2025) in the utility room, and the DON stated that it looked like the same liquid in both cups and the liquids were almost the same blue color as the mouthwash. The DON stated that the difference between H&BS and mouthwash was texture. The DON stated that staff should not leave soap or shampoo in a drinking cup for safety reasons, and it could be confused and mistakenly consumed by a confused resident. The DON stated that staff should use a small individual bottle of shampoo and body wash when providing bed bath in the resident ' s room or in the showers in the resident ' s bathroom. During a review of the facility ' s policy and procedure (P&P) titled, Homelike Environment, last reviewed on 1/8/2025, the P&P indicated, Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. During a review of the facility ' s P&P titled, Manual Lifting and Materials Storage, last reviewed on 1/8/2025, the P&P indicated, Heavier, bulk items should be transferred to smaller containers for employee use. Ensure all temporary containers are properly labeled. During a review of the facility ' s P&P titled, Safety Precautions, General, last reviewed on 1/8/2025, the P&P indicated, All personnel shall follow general safety precautions established by this facility Do not leave work areas unattended where supplies or equipment are being used Follow manufacturer ' s directions when using chemicals, equipment, and other supplies.