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	04/16/2025

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50033 Based on observation, interview, and record review, the facility failed to protect the residents ' right to be free from abuse (deliberately aggressive or violent behavior with the intention to cause harm) for two of four sampled residents (Residents 1 and 2) when on 4/12/2025, Residents 1 and 2, while in their wheelchairs in a hallway, Resident 2 grabbed Resident 1 ' s right arm while Resident 1 grabbed Resident 2 ' s arm. The residents (Residents 1 and 2) then pushed against each other ' s hands and arms, and each resident (Residents 1 and 2) received abrasions (when the surface layers of the skin have been broken). This deficient practice resulted in Resident 1 and Resident 2 being subjected to physical abuse while under the care of the facility. Resident 1 sustained two abrasions: one on the right forearm (part of the arm between the elbow and the wrist) and one on the right hand that needed first aid (initial assistance and care given to a resident who has been injured) and daily wound treatments. Resident 2 sustained an abrasion on the right arm that needed first aid. Findings: During a review of Resident 1 ' s Admission Record, the Admission Record indicated the facility originally admitted the resident on 11/23/2024 and readmitted on [DATE], with diagnoses including but not limited to, encephalopathy (damage or disease that affects the brain), heart disease, and vascular dementia (a progressive state of decline in mental abilities caused by decreased blood flow to the brain). During a review of Resident 1 ' s Minimum Data Set (MDS - a resident assessment tool), dated 2/26/2025, the MDS indicated Resident 1 can make self-understood and understand others. The MDS indicated Resident 1 required moderate assistance with most activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 1 ' s Situation, Background, Assessment, Recommendation (SBAR-a communication tool used by healthcare workers when there is a change of condition among the residents), dated 4/12/2025, the SBAR indicated Resident 1 had a physical altercation (confrontation or fight that involves physical contact, pushing, shoving, or other forms of aggressive behavior) with Resident 2 on 4/12/2025 at 3:50 p.m. in front of the patio door and sustained right arm abrasions. The SBAR indicated Resident 1 stated that Resident 2 grabbed his wheelchair, pushed him aside to get through, and put his hand on his right arm causing his right arm to bleed. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0600 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1 ' s Non-Pressure Sore Skin Problem Report (a report documenting skin injuries that are not caused by pressure, but rather other factors), dated 4/12/25, the Non-Pressure Sore Skin Problem Report indicated Resident 1 had a right arm skin abrasion (when the surface layers of the skin have been broken). During a review of Resident 1 ' s Order Summary Report (physician orders), the Order Summary Report indicated an order dated 4/12/2025 to cleanse a right arm abrasion with normal saline (a saltwater solution), pat dry, and cover with a dry dressing daily. During a review of Resident 2 ' s Admission Record, the Admission Record indicated the facility originally admitted the resident on 1/10/2019 and readmitted on [DATE], with diagnoses including but not limited to, type two diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), and reduced mobility (the ability to move freely). During a review of Resident 2 ' s Minimum Data Set (MDS - a resident assessment tool), dated 1/31/2025, the MDS indicated Resident 2 had severely impaired cognition (the ability to think and make decisions) and 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 2 ' s Interdisciplinary Team (IDT-a group of healthcare professionals working together to provide comprehensive care to patients) notes, dated 1/31/2025, the IDT notes indicated Resident 2 had a diagnosis of psychosis (a mental disorder characterized by a disconnection from reality) manifested by uncontrollable extreme mood swings (sudden or intense changes in a person ' s emotional state) causing verbal (having to do with words) expression of anger. During a review of Resident 2 ' s SBAR, dated 4/12/2025, the SBAR indicated on 4/12/2025 at 3:50 p.m. Resident 2 stated that Resident 1 grabbed his wheelchair, pushed him aside, and scratched his right arm. At 4:30 pm, 911 (emergency number to request emergency assistance) was called per facility protocol. Resident 2 ' s responsible party (RP) and physician were notified at 6:41 pm. At 5:39 pm, the police came and was provided report by the licensed nurse (name not indicated). At 8:33 pm, Resident 2 was transferred to a general acute care hospital (GACH) emergency department for a psyche evaluation. During a review of Resident 2 ' s Non-Pressure Sore Skin Problem Report, dated 4/12/25, the Non-Pressure Sore Skin Problem Report indicated Resident 2 had a right arm skin abrasion. During a review of Resident 2 ' s Order Summary Report, the Order Summary Report indicated an order dated 4/12/2025 to cleanse the right arm with normal saline, pat dry, and cover with a dry dressing daily. (continued on next page)

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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 0600 Level of Harm - Actual harm Residents Affected - Few	During a concurrent observation and interview on 4/15/2025 at 10:03 a.m. with Resident 1 in Resident 1 ' s room, Resident 1 had one bandage on his (Resident 1) right forearm and one bandage on his (Resident 1) right hand. Resident 1 stated he (Resident 1) was injured when he (Resident 1) and another resident (Resident 2) were moving towards each other while in their (Residents 1 and 2) wheelchairs in the hallway. Resident 1 stated the other resident (Resident 2) grabbed his (Resident 1) arm when (Resident 2) was passing and said, That is what you get for going on my side. Resident 1 stated he (Resident 1) usually has pain in his (Resident 1) right arm but the scratches on his (Resident 1) arm caused additional pain. Resident 1 stated he (Resident 1) also grabbed the other resident ' s (Resident 2) arm between his (Resident 2) elbow and shoulder and injured him (Resident 2) as well. During an interview on 4/15/2025 at 4:05 p.m. with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated on 3/12/2025 he (CNA 1) was at the nursing station when he (CNA 1) heard somebody yelling. CNA 1 stated he then turned his (CNA 1) head and saw Resident 1 grabbing Resident 2 ' s arm with his (Resident 1) hand, and Resident 2 grabbing Resident 1 ' s arm with his (Resident 2) hand at the same time. CNA 1 stated both residents (Residents 1 and 2) were putting pressure on each other and moving their hands and arms back and forth. CNA 1 stated when the residents (Residents 1 and 2) released each other, Resident 1 had two bleeding areas on his (Resident 1) arm and Resident 2 had one bleeding area on his (Resident 2) arm. CNA 1 stated he (CNA 1) was not sure which resident (Resident 1 or Resident 2) grabbed the other first. CNA 1 stated they (Residents 1 and 2) were intentionally (doing something on purpose) grabbing each other. During an observation on 4/16/2025 at 10:15 a.m. with Treatment Nurse 1 (TN 1) in Resident 1 ' s room, TN 1 removed the bandages from Resident 1 ' s right arm to perform wound care. Resident 1 had two wounds: one on the right forearm and one on the right hand. Each wound had bloody drainage. TN 1 measured the wound on the right forearm as 2.0 centimeters (cm) by 0.2 cm. TN 1 measured the wound on the right hand as 1.0 cm by 0.5 cm. During an interview on 4/16/2025 at 1:55 p.m. with the Administrator (Adm) and the Director of Nursing (DON), the Adm stated she did not think there was abuse between Residents 1 and 2. The Adm stated this was an accident between Residents 1 and 2 when they were trying to get around each other in the hallway. The DON stated she (DON) did not think abuse occurred and the residents (Residents 1 and 2) were trying to protect themselves while moving around each other. During a review of the current facility-provided policy and procedure titled, Abuse, Neglect (is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress), Exploitation (taking advantage of a resident for personal gain through the use of manipulation , intimidation, threats, or coercion) and Misappropriation (the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident ' s belongings or money without the resident ' s consent) Prevention Program, revised April 2021, the policy and procedure indicated, Residents have the right to be free from abuse The policy and procedure indicated the facility will Protect residents from abuse . by anyone including . other residents.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50033 Based on observation, interview, and record review, the facility failed to ensure two of four sampled residents (Residents 1 and 2) received treatment and care in accordance with professional standards of practice by failing to measure Resident 1 and Resident 2 ' s wounds during the assessment of new wounds. This deficient practice had the potential to result in improper wound care and a delay in wound healing to Residents 1 and 2. Findings: During a review of Resident 1 ' s Admission Record, the Admission Record indicated the facility originally admitted the resident on 11/23/2024 and readmitted on [DATE], with diagnoses including but not limited to, encephalopathy (damage or disease that affects the brain), heart disease, and vascular dementia (a progressive state of decline in mental abilities caused by decreased blood flow to the brain). During a review of Resident 1 ' s Minimum Data Set (MDS - a resident assessment tool), dated 2/26/2025, the MDS indicated Resident 1 had severely impaired cognition (the ability to think and make decisions) and required moderate assistance with most activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 1 ' s Non-Pressure Sore Skin Problem Report, dated 4/12/25, the Non-Pressure Sore Skin Problem Report indicated Resident 1 had a new right arm skin abrasion (when the surface layers of the skin have been broken). The Non-Pressure Sore Skin Problem Report did not indicate any measurements of the abrasion. During a review of Resident 1 ' s Order Summary Report (physician orders), the Order Summary Report indicated an order dated 4/12/2025 to cleanse a right arm abrasion with normal saline (a saltwater solution), pat dry, and cover with a dry dressing daily. During a review of Resident 2 ' s Admission Record, the Admission Record indicated the facility originally admitted the resident on 1/10/2019 and readmitted on [DATE], with diagnoses including but not limited to, type two diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), and reduced mobility. During a review of Resident 2 ' s Minimum Data Set (MDS - a resident assessment tool), dated 1/31/2025, the MDS indicated Resident 2 had severely impaired cognition (the ability to think and make decisions) and 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 2 ' s Non-Pressure Sore Skin Problem Report, dated 4/12/25, the Non-Pressure Sore Skin Problem Report indicated Resident 2 had a new right arm skin abrasion. The Non-Pressure Sore Skin Problem Report did not indicate any measurements of the abrasion. (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2 ' s Order Summary Report, the Order Summary Report indicated an order dated 4/12/2025 to cleanse the right arm with normal saline, pat dry, and cover with a dry dressing daily. During an observation and interview on 4/16/2025 at 10:15 a.m. with Treatment Nurse 1 (TN 1) in Resident 1 ' s room, Resident 1 had two wounds: one on the right forearm and one on the right hand. TN 1 measured the wound on the right forearm as 2.0 centimeters (cm) by 0.2 cm. TN 1 measured the wound on the right hand as 1.0 cm by 0.5 cm. During an interview on 4/16/2025 at 11:40 a.m. with Treatment Nurse 2 (TN 2), TN 2 stated he evaluated new wounds on Resident 1 and Resident 2 on 4/12/2025. TN 2 stated he observed two abrasions on Resident 1: one on the right forearm and one on the right hand. TN 2 stated he observed one abrasion on Resident 2 ' s right arm near the wrist. TN 2 stated he did not document measurements of any of the wounds on Resident 1 or Resident 2. TN 2 stated the wound measurements should have been documented so they can ensure they are treating the wounds correctly. During an interview on 4/16/2025 at 12:00 p.m. with the Director of Nursing (DON), the DON stated Resident 1 and 2 ' s wounds should have been measured on the day they were first assessed. The DON stated the wounds should have been measured to get a baseline size so they can monitor treatment and know if they are getting bigger or smaller. During a review of the facility ' s policy and procedure titled, Wound Care, revised October 2010, the policy and procedure indicated to document all assessment data (i.e., wound bed color, size, drainage, etc.) obtained when inspecting the wound.