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	08/14/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review the facility failed to ensure staff were not standing over a resident while assisting with feeding for one of three sampled residents (Resident 3).This deficient practice had the potential to affect the resident's self-esteem, self-worth, and sense of independence. During a review of Resident 3's admission Record, the admission Record indicated the facility readmitted the resident on 7/25/2024 with diagnoses including anoxic brain damage (when the brain is deprived of oxygen entirely, leading to the death of brain cells and potential permanent damage after just a few minutes), epileptic seizure (a sudden, abnormal surge of electrical activity in the brain that can cause temporary changes in movement, behavior, sensations, or awareness), and dysphagia, oral phase (difficulty swallowing that originates in the mouth).During a review of Resident 3's Minimum Data Set (MDS - a resident assessment tool) dated 5/27/2025, the MDS indicated Resident 3's cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) was severely impaired. The MDS indicated Resident 3 was dependent on staff with eating, oral hygiene, toileting hygiene, shower/bath self, and personal hygiene.During a meal observation on 8/14/2025 at 1:45 p.m., in Resident 3's room, observed Certified Nursing Assistant 1 (CNA 1) assisting Resident 3 with feeding and standing over and hovering over Resident 3.During an interview on 8/14/2025 at 1:49 p.m., with CNA 1, CNA 1 stated that she (CNA 1) was standing while assisting Resident 3 with lunch because she could not find a chair to sit on. CNA 1 continued to state that she knows she is supposed to sit down on a chair while assisting residents with feeding, however she was unable to find a chair to sit on.During an interview on 8/14/2025 at 3:05 p.m., with the Director of Staff Development (DSD), the DSD stated that staff should be sitting at eye level while assisting with feeding. The DSD stated staff should be sitting at eye level for residents' dignity and respect. The DSD continued to state that staff should be sitting down so that residents will not feel intimidated while being assisted with feeding.During a review of the facility's policy and procedure (P&P) titled, Assistance with Meals, review date 1/8/2025, the P&P indicated residents shall receive assistance with meals in a manner that meets the individual needs of each resident. Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity, for example: a. not standing over residents while assisting them with meals.During a review of the facility's P&P titled, Dignity, review date 1/8/2025, the P&P indicated each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem.

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
	056133	A. Building B. Wing	08/14/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1) received care and services in accordance with professional standards of practice by:1.Failing to administer Resident 1's doxycycline monohydrate (antibiotic used to treat a wide range of bacterial infections), mirtazapine (medication used to treat depression [a mood disorder characterized by a persistent feeling of sadness and loss of interest in activities, which significantly impacts daily life]), atorvastatin (lowers cholesterol and triglyceride [fats] levels in the blood), and omeprazole (medication used to reduce the amount of acid produced by the stomach) as prescribed by the physician.This deficient practice resulted in the omission of medications which could have resulted in severe health complications.2. Failing to ensure licensed nurses informed Resident 1's physician of Resident 1's medications not being available and not administering Resident 1's doxycycline monohydrate, mirtazapine, atorvastatin on 8/2/2025 and omeprazole on 8/3/2025.This deficient practice had the potential to place Resident 1 at risk of not receiving therapeutic dosages (amount needed to treat a disease) of missed medications. During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 8/2/2025 with diagnoses that included chronic osteomyelitis (bone infection), right ankle and foot, type 2 diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing) with foot ulcer (a small open sore or wound generally found in the stomach or on the skin), major depressive disorder, and mixed hyperlipidemia (a condition in which there are high levels of fat particles [lipids] in the blood). During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 8/7/2025, the MDS indicated the resident had the ability make self-understood and had the ability to understand others. The MDS indicated that Resident 1 required set up or clean up assistance with eating and oral hygiene and required substantial/maximal assistance from staff with toileting hygiene and personal hygiene. During a review of Resident 1's Order Summary Report, the Order Summary Report indicated the following orders: - Doxycycline monohydrate oral tablet 100 milligram (mg- unit of measurement), give one (1) tablet by mouth every 12 hours for corynebacterium striatum (type of bacteria associated with infections) for 30 days, ordered 8/2/2025. - Mirtazapine oral tablet 15 mg, give one (1) tablet by mouth at bedtime for depression manifested by verbalization of sadness, ordered 8/2/2025.- Atorvastatin calcium oral tablet 40 mg, give one (1) tablet by mouth at bedtime for hyperlipidemia, ordered 8/2/2025.- Omeprazole magnesium oral capsule 20 mg by mouth one time a day for hiatal hernia (occurs when part of the stomach bulges into the chest), ordered 8/2/2025.During a review of Resident 1's pharmacy delivery manifest (delivery receipt), the pharmacy delivery manifest indicated the following medications were delivered on 8/3/2025 at 7:57 a.m.: doxycycline monohydrate, mirtazapine, atorvastatin, omeprazole. During a review of Resident 1's Licensed Nurses Note dated 8/2/2025 timed at 3:00 p.m., the Licensed Nurses note indicated Resident 1 was admitted today (8/2/2025) at 2:30 p.m. Physician notified after hours physician. All orders clear. Around 8:30 p.m., spoke with Resident 1's daughter regarding Resident 1's medications, stated to her that when residents get discharged from the hospital, they don't usually come with medications and that the facility does not have an in-house pharmacy. Stated to Resident 1's daughter that the facility's pharmacy usually takes six (6) hours . Also specified that LVN 1 cannot guarantee exactly what time medications will arrive. During a concurrent interview and record review on 8/14/2025 at 2:35 p.m., with the MDS Nurse (MDSN), reviewed Resident 1's Medication Administration Record (MAR- a report detailing the medications administered to a resident) dated 8/2025 and nursing progress notes for 8/2025. The MDSN stated all medications should be administered per physician's order. The MDSN continued to state that if medications are not administered, residents' physicians should be made aware of the missed medication dose so that licensed nurses can receive new orders for a missed medication dose if needed. The MDSN stated that Resident 1's doxycycline monohydrate, mirtazapine, atorvastatin were not administered on 8/2/2025 and omeprazole was not administered on 8/3/2025. During an interview on 8/14/2025 at 3:32 p.m., with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated that LVN 1 did not administer Resident 1's doxycycline monohydrate, mirtazapine, and atorvastatin because Resident 1 was a new admit on 8/2/2025 at around 3:00 p.m. and the facility had not received Resident 1's medications. LVN 1 stated that he (LVN 1) went through the emergency kit (e-kit a pre-packaged, set of medications kept onsite for immediate use) to look for the medications, however, none of Resident 1's medications were in the e-kit. LVN 1 stated the facility does not have an in-house pharmacy, and the facility has to wait for an outside pharmacy to deliver all medications. LVN 1 continued to state