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	08/29/2025

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 0627 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (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 0627 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a safe and orderly discharge was provided to two of three sampled residents (Resident 1, who had severely impaired cognition [the mental action or process of acquiring knowledge and understanding through thought, experience and the senses], lacked capacity to understand and make decisions, and required staff assistance for all Activities of Daily Living [ADL - basic tasks that individuals perform to maintain their daily lives] and Resident 2, who also required staff assistance for all ADLs) by failing to:1. Ensure that the post-discharge destination and continuing care provider were capable of meeting the needs of Resident 1 and Resident 2 prior to discharge. 2. Ensure that an effective discharge plan addressing the health and safety needs of Resident 1 and Resident 2 was provided by failing to complete all sections of the Post-Discharge Plan of Care for both residents (Resident 1 and Resident 2). 3. Ensure that the physicians for Resident 1 and Resident 2 documented information about the basis for the discharge in their medical records. 4. Implement the following facility discharge policies and procedures (P&P): - Transfer or Discharge, preparing a Resident for - indicating residents will be prepared in advance for discharge.- Discharge Summary and Plan - indicating a discharge summary and post-discharge plan will be developed and re-evaluated by the Interdisciplinary Team (IDT - a group of health care professionals with various areas of expertise who work together toward the goals of their resident) to assist the resident to adjust to his/her new living environment.These deficient practices resulted in Resident and Resident 2 being discharged to an unlicensed Board and Care (BC 1 - small residential homes that provide room, meals, and assistance with daily living activities for individuals needing care, but don't require 24-hour skilled nursing care) on 8/8/2025. On 8/19/2025, Resident 1 required an emergency transfer from BC 1 to General Acute Care Hospital 1 (GACH 1) and was treated for anorexia (a general loss of appetite that can be caused by illness or medications), altered level of consciousness (ALOC - when a person is not as awake, alert, or responsive to their surroundings as they should be), pulmonary congestion (abnormal buildup of fluid in the lungs) and urinary tract infection (UTI - an infection in the bladder [muscular organ that stores urine] or urinary tract [refers to the system of organs that produce, store, and excrete urine]) and possible early sepsis (a life-threatening condition that occurs when the body's immune system overreacts to an infection). Resident 1 was then transferred to Skilled Nursing Facility 2 (SNF 2) on 8/26/2025.On 8/19/2025, Resident 2 required transfer from BC 1 to GACH 2 and was treated for hyperkalemia (abnormally high potassium [an essential mineral crucial for the proper functioning of the body including nerve function, muscle contractions and maintain a regular heartbeat, normal range: 3.5 to 5.2 milliequivalent per liter {mEq/l - unit of measure}] levels in the blood and can be life-threatening, especially if it develops quickly, as it can cause serious heart problems like irregular rhythms, muscle weakness, or even paralysis [inability to move]). Resident 2 was then transferred back to Skilled Nursing Facility 1 (SNF 1) on 8/21/2025.On 8/28/2025 at 3:28 p.m., while onsite at the facility, the State Survey Agency (SSA) called an Immediate Jeopardy (IJ - a situation in which the facility's non-compliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) in the presence of the Administrator (ADM), Quality Assurance Nurse Consultant (QANC) and the Medical Records Director (MRD) due to the facility's failure to ensure Resident 1 and Resident 2 were provided with a safe and orderly discharge when on 8/8/2025, Resident 1 and Resident 2 were discharged to an unlicensed board and care (BC 1).On 8/29/2025 at 2:15 p. m., the QANC provided an acceptable IJ Removal Plan (a detailed plan to address the IJ findings) for the facility's failure to ensure Resident 1 and Resident 2 were provided with a safe and orderly discharge when on 8/8/2025, Resident 1 and Resident 2 were discharged to an unlicensed board and care (BC 1).On 8/29/2025 at 4:44 p.m., while onsite at the facility, the SSA verified and confirmed the facility's full implementation of the accepted IJ removal plan through observations, interviews and record reviews, and determined the IJ situation regarding facility's failure to ensure Resident 1 and Resident 2 were provided with a safe and orderly discharge was no longer present. The SSA removed the IJ on 8/29/2025 at 5:19 p.m., in the presence of the ADM and QANC.The acceptable IJ Removal Plan included the following summarized actions:1. Resident 1 is no longer at the facility. Resident 1 was discharged to a lower level of care (BC 1) on 8/8/2025. During a welfare check (a service to ensure the well-being of a resident) conducted on 8/27/2025, the facility found out that Resident 1 had been admitted to GACH 1. Facility staff contacted GACH 1 and found out that Resident 1 had been discharged to SNF 2 on 8/26/2025. The facility then completed a welfare