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	12/23/2025

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement its policy and procedure (P&P) on abuse for an allegation of sexual abuse for one of two sampled residents (Resident 1) by failing to: 1. Conduct a thorough investigation into alleged sexual abuse.2. Complete and submit a written five (5) day follow-up investigation report indicating the results of an investigation for the allegation of sexual abuse that occurred on 12/18/2025. This deficient practice had the potential to place Resident 1 at risk for further sexual exploitation and resulted in a delay in the investigation of a suspicion of sexual abuse.Findings: a. During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 4/2/2025 with diagnoses including diverticulitis (inflammation or infection of small pouches (diverticula) in the colon, causing symptoms like lower-left abdominal pain, fever, nausea, and changes in bowel habits), moderate protein-calorie malnutrition (a severe deficiency from not getting enough protein and calories (energy) to meet the body's needs), overactive bladder (a common condition marked by a sudden, uncontrollable urge to urinate, often leading to frequent bathroom trips, nighttime awakenings, and sometimes urine leakage before reaching the toilet), and major depressive disorder (a mood disorder characterized by persistent feelings of sadness, loss of interest, and a range of other emotional and physical symptoms that significantly interfere with daily life). During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 10/7/2025, the MDS indicated Resident 1 had moderate cognitive (the mental process involved in knowing, learning, and understanding things) impairment. The MDS indicated Resident 1 required partial/moderate assistance with toileting hygiene, lower body dressing, and personal hygiene. During a review of Resident 1's Licensed Nurse Note dated 12/18/2025, timed at 6:26 p.m., the Licensed Nurse Note indicated Resident 1 claimed Resident 2 came into Resident 1's room and tickled Resident 1's feet. The Licensed Nurse Notes further indicated that the Social Service Director (SSD) is aware and will follow up to move Resident 1 to another room to avoid problems. During an interview on 12/22/2025 at 1:15 p.m. with Resident 1, Resident 1 stated that on Wednesday evening, not sure what time, on 12/17/2025, Resident 2 entered Resident 1's room. Resident 1 stated that Resident 1's roommate is Resident 2's mother, consequently, Resident 2 comes in Resident 1's room often. On the evening of 12/17/2025, Resident 1 was lying in bed with her eyes closed and awake. Resident 2 came to Resident 1's side of the bed, placed his hand underneath Resident 1's blanket and tickled Resident 1's left foot. Resident 1 stated that Resident 1 was startled and told Resident 2 to stop. Resident 1 stated that when she told Resident 2 to stop, he stopped and exited the room. Resident 1 stated that she thought that Resident 2 wanted to have sex with her. Resident 1 stated that she did not consent to be tickled by Resident 2. Resident 1 continued to state that she did not report the incident on 12/17/2025, however she reported the incident to Certified Nursing Assistant 1 (CNA 1) the following morning on 12/18/2025. b. During a review of Resident 2's admission Record, the admission Record indicated the facility readmitted Resident 2 on 5/22/2024 with diagnoses including major depressive disorder and unspecified dementia (a progressive state of decline in mental abilities). During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2 had severe cognitive impairment. The MDS indicated Resident 2 required substantial/maximal assistance with toileting hygiene and partial/moderate assistance with personal hygiene. During an interview on 12/22/2025 at 1:54 p.m., with the SSD, the SSD stated that the SSD was made aware that Resident 2 made Resident 1 feel uncomfortable when Resident 2 tickled Resident 2's feet on 12/18/2025 at around 9 a.m. During an interview on 12/22/2025 at 2:20 p.m., with CNA 1, CNA 1 stated that on the morning of 12/18/2025, at around 7:45 a.m., Resident 1 informed CNA 1 that Resident 2 came into Resident 1's room and touched Resident 1's feet. CNA 1 stated that she reported the incident to Licensed Vocational Nurse 1 (LVN 1) because she (Resident 1) was about to cry when Resident 1 was talking about the incident. CNA 1 stated that Resident 2 touching Resident 1's feet without Resident 1's permission is inappropriate. Residents should not be touching other residents without permission. During an interview on 12/22/2025 at 2:45 p.m. with LVN 1, LVN 1 stated that on 12/18/2025 at around 8 a.m. CNA 1 reported to LVN 1 that Resident 1 reported to CNA 1 that Resident 2 touched her foot last night (12/17/2025) and was crying. After CNA 1 reported to LVN 1, LVN 1 went to check on Resident 1. LVN 1 stated that she asked Resident 1 what happened and Resident 1 reported to LVN 1 that on the evening of 12/17/2025 Resident 2 came into Resident 1's room and tickled Resident 1's foot. LVN 1 stated that she asked Resident 1 if Resident 2 touched her anywhere else and Resident 1 responded No. LVN 1 continued

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement policies and procedures (P&P) to ensure the reporting of a reasonable suspicion of a crime in accordance with Section 1150B of the Act by failing to report an allegation of sexual abuse for one of two sampled residents (Resident 1) to the State Survey Agency (SSA) within the required timeframe. This deficient practice had the potential to place Resident 1 at risk for further sexual exploitation and resulted in a delay in the investigation of a suspicion of sexual abuse. Findings:a). During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 4/2/2025 with diagnoses including diverticulitis (inflammation or infection of small pouches (diverticula) in the colon, causing symptoms like lower-left abdominal pain, fever, nausea, and changes in bowel habits), moderate protein-calorie malnutrition (a severe deficiency from not getting enough protein and calories (energy) to meet the body's needs), overactive bladder (a common condition marked by a sudden, uncontrollable urge to urinate, often leading to frequent bathroom trips, nighttime awakenings, and sometimes urine leakage before reaching the toilet), and major depressive disorder (a mood disorder characterized by persistent feelings of sadness, loss of interest, and a range of other emotional and physical symptoms that significantly interfere with daily life). 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Resident 1 stated that when she told Resident 2 to stop, he stopped and exited the room. Resident 1 stated that she thought that Resident 2 wanted to have sex with her. Resident 1 stated that she did not consent to be tickled by Resident 2. Resident 1 continued to state that she did not report the incident on 12/17/2025. However, she reported the incident to Certified Nursing Assistant 1 (CNA 1) the following morning on 12/18/2025. During an interview on 12/22/2025 at 1:54 p.m., with the SSD, the SSD stated that the SSD was made aware that Resident 2 made Resident 1 feel uncomfortable when Resident 2 tickled Resident 1's feet on 12/18/2025 at around 9 a.m. During an interview on 12/22/2025 at 2:20 p.m., with CNA 1, CNA 1 stated that on the morning of 12/18/2025, at around 7:45 a.m., Resident 1 informed CNA 1 that Resident 2 came into Resident 1's room and tickled Resident 1's feet. 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LVN 1 stated that she asked Resident 1 if Resident 2 touched her anywhere else and Resident 1 responded No. LVN 1 continued to state that Resident 1 stated that she thought Resident 2 wanted to have sex with her (Resident