

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/13/2026
NAME OF PROVIDER OR SUPPLIER West Hills Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0777</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that a physician's stat (immediate) order for an X-radiation (x-ray - a type of medical imaging that uses radiation to take pictures of the inside of the body) was completed timely for one of four sampled residents (Resident 2), following Resident 2's fall, in accordance with the facility's policy and procedure (P&P), titled Stat Orders, last reviewed on 1/8/2025 which indicated that stat orders are to be completed promptly within a four to six-hour time frame. This deficient practice had the potential for delay of treatment and services to Resident 2 following the resident's fall. Findings: During a review of Resident 2's admission Record, the admission Record indicated that Resident 2 was originally admitted to the facility on [DATE] with diagnoses including diverticulosis (small pouches) of large intestine without perforation (a hole had formed through the wall of a hollow body organ) or abscess (swollen pocket of pus) without bleeding, asthma (chronic lung condition where airways become inflamed, swollen, narrow making it hard to breathe), and unspecified abnormalities of gait (walking pattern) and mobility (movement). During a review of Resident 2's Minimum Data Set (MDS- a resident assessment tool) dated 1/5/2026, the MDS indicated that Resident 2 had severely impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) and required moderate (helper does less than half the effort) to maximal (helper does more than half the effort) assistance on staff with toileting hygiene, shower or bathing, dressing, personal hygiene, and mobility (movement). During a review of Resident 4's admission Record, the admission Record indicated the facility initially admitted Resident 4 to the facility on [DATE] and readmitted the resident on 8/26/2025, with diagnoses including muscle weakness and cerebral palsy (a group of conditions that affect movement and posture cause by damage to the developing brain). During a review of Resident 4's MDS dated [DATE], the MDS indicated Resident 4's cognition was moderately impaired. During a review of Resident 4's History and Physical (H&P) dated 8/25/2025, the H&P indicated Resident 4 had the capacity to understand and make decisions. During a review of Resident 2's Change of Condition (COC-a change in resident's health that requires immediate observation, assessment and intervention)/Interact assessment form dated 1/1/2026 and timed at 7:40 p.m., the COC/Interact assessment form indicated that Resident 2's roommate (Resident 4) pressed the call light to notify staff that Resident 2 was on the floor mat. The COC indicated Resident 4 stated that Resident 2 was coming back from the bathroom and fell on his back on the floor mat. The COC indicated Registered Nurse (RN 3) Supervisor assessed Resident 2, who reported left wrist pain rated at 3/10 (pain scale rating indicating mild pain; 0=no pain, 10=worst pain imaginable). The physician and the responsible party were notified. The physician called back on 1/1/2026 at 7:45 p.m., with orders for X-ray of the left wrist and Tylenol 325 milligrams (mg-unit of mass or weight) for pain. The COC indicated the RN Supervisor (RN 3) noted and carried out the orders. During a review of Resident 2's Order Details, the Order Details indicated an order dated</p> <p>(continued on next page)</p>

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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<p>F 0777</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1/1/2026 at 8:47 p.m., for a Stat Left Wrist X-ray. During a review of Resident 2's Radiology Results Report dated 1/2/2026, the Radiology Results Report indicated the examination was conducted on 1/2/2026 at 8:38 a.m., and the results were reported on 1/2/2026 at 8:47 a.m. The report indicated Resident 2 had an acute nondisplaced fracture (broken bone) of the distal (farther away from the center of the body) radius (long bone in the forearm). During a review of Resident 2's Discharge Summary Report dated 1/2/2026 timed at 2:51 p.m., the Discharge Summary Report indicated Resident 2 was transferred to a general acute care hospital (GACH) on 1/2/2026 at 1:53 p.m. due to status post (S/P-after the condition of) fall and acute nondisplaced fracture of left distal radius. During a telephone interview, on 1/13/2026 at 3:12 p.m., with Registered Nurse 4, (RN 4), RN 4 stated that she worked on 1/1/2026 from 11:00 p.m. to 7:00 a.m. and acknowledged that she should have followed up on the physician's stat order for an X-ray of Resident 2's left wrist. RN 4 stated that according to the facility's policy and procedures, a stat X-ray order is required to be completed within four to six hours. RN 4 further stated that her failure to follow up on the stat order placed Resident 2 at risk of not receiving appropriate care, with the potential for untreated pain or injury. During an interview, on 1/13/2026 at 4:15 p.m., with the Director of Nursing, the DON stated not following up on the on the Stat order placed Resident 2 at risk for not receiving proper care and experiencing delayed care resulting in untreated pain or injury to the resident. During a review of the facility's laboratory services policy and procedure (P&P), titled Stat Orders last reviewed on 1/8/2025, the policy indicated it is the goal of the facility to complete STAT orders promptly within a 4-to-6-hour time frame.</p>		