STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555578	A. Building B. Wing	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holiday Manor Care Center	20554 Roscoe Blvd Canoga Park, CA 91306

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42275 Based on observation, interview, and record review, the facility failed to notify two of five sampled residents (Resident 2 and Resident 3) physician, when on 9/24/2024, Resident 2 and Resident 3 had changes in their skin condition. Resident 2 had dry flaky skin on both hands, itchiness, crust on both palms and Resident 3 had dry flaky skin on the right palm and itchiness. This deficient practice resulted in a delay of medical care and treatment which could have resulted in a negative impact to Resident 2 ' s and Resident 3 ' s well-being. Findings: a. During a review of Resident 2 ' s Admission Record indicated the facility originally admitted Resident 2 on 6/8/2022 and readmitted on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD - a group of diseases that cause airflow blockage and breathing-related problems) and pruritis (medical term for itching, or the feeling on the skin that makes you want to scratch). During a review of Resident 2 ' s Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 7/2/2024, indicated Resident 2 was usually able to make self-understood and understand others. The MDS indicated that Resident 2 was dependent on staff for showers, toileting hygiene, and oral hygiene. During a concurrent observation and interview on 9/24/2024 at 8:37 a.m. with Treatment Nurse 1 (TN 1) and Resident 2, observed Resident 2 ' s both hands had dry flaky skin and both palms were crusted. Resident 2 stated that his (Resident 2) skin was itchy, so he was scratching. When Resident 2 was asked how long his hands were dry and flaky, Resident 2 was unable to answer the question. TN 1 stated that there are no orders in place to address and treat Resident 2 ' s dry flaky hands and crusted palms. TN 1 stated that he (TN 1) will immediately notify Resident 2 ' s physician to obtain treatment. b. During a review of Resident 3 ' s Admission Record indicated the facility originally admitted Resident 3 on 2/23/2024 and readmitted on [DATE] with diagnoses that included Alzheimer ' s disease (a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks) and type two diabetes mellitus (a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel). (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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Holiday Manor Care Center	20554 Roscoe Blvd Canoga Park, CA 91306

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 3 ' s MDS dated [DATE], indicated Resident 3 was usually able to make self-understood and understand others. The MDS indicated that Resident 3 was dependent on staff for showers, needed maximum assistance for toileting hygiene, and moderate assistance for oral hygiene. During a concurrent observation and interview on 9/24/2024 at 8:50 a.m., with Certified Nursing Assistant 1 (CNA 1), in Resident 3 ' s room, observed Resident 3 had dry flaky skin on the right palm. Resident 3 stated that her (Resident 3 ' s) right palm was itchy. CNA 1 stated that changes in Resident 3 ' s skin condition on the right palm was reported to TN 1 about two weeks ago (unable to recall specific date). During an interview with TN 1 on 9/25/2024 at 3:50 p.m., TN 1 stated that he (TN 1) did not receive the report from staff about Resident 3 ' s right palm until yesterday (9/24/2024). TN 1 stated he then notified Resident 3 ' s physician and obtained treatment for Resident 3 ' s right palm. During an interview and record review with the Director of Nursing (DON) on 10/2/2024 at 1:40 p.m., the DON stated that the CNAs should have filled out the Stop and Watch form (an early warning tool that helps facility staff identify and communicate changes in a resident ' s condition) when they observed any changes including skin conditions. The DON stated that by not completing the Stop and Watch form and only notifying the licensed nurses verbally, the changes in residents ' condition could be omitted (leave unmentioned or undone) easily and not followed up. The DON further stated that she (DON) was not able to find documented evidence of the Stop and Watch form for Resident 2 and Resident 3 ' s skin conditions. The DON stated that the facility was not able to notify Resident 2 and Resident 3 ' s physician of the changes in Resident 2 and Resident 3 ' s skin condition. The DON stated that the facility did not start the care and treatment for both residents ' hands observed by the surveyor and findings confirmed by TN 1 on 9/24/2024 until after the surveyor ' s on site visit. During a review of the facility ' s policy and procedure titled Change in a Resident ' s Condition or Status last reviewed 7/30/2024, indicated, Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident ' s medical/mental condition and/or status Need to alter the resident ' s medical treatment significantly.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42275 Based on observation, interview, and record review, the facility failed to implement infection control practices by: 1. Failing to store a mouthpiece (used to inhale a mist of liquid medicine that is created by a handheld nebulizer [HHN - a small, portable device that turns liquid medication into a mist that can be inhaled into the lungs]) and tubing of HHN in a bag when not used for one of five sampled residents (Resident 5). 2. Failing to report more than two suspected cases of scabies (a contagious skin condition characterized by a rash [an area of the skin that has changes in texture or color and may look inflamed or irritated] and intense itching) for two of five sampled residents (Resident 2 and Resident 3). This deficient practice had the potential to result in the spread of cross contamination (the physical movement or transfer of harmful bacteria [germs] from one person, object, or place to another) and scabies among staff and other residents. Findings 1. During a review of Resident 5's Admission Record indicated the facility originally admitted Resident 5 on 3/15/2023 and readmitted on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD - a group of diseases that cause airflow blockage and breathing-related problems) and Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks). During a review of Resident 5's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 9/9/2024, indicated Resident 5's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was severely impaired. The MDS further indicated that Resident 5 needed supervision or touching assistance for oral hygiene, personal hygiene, and mobility (movement). During a review of Resident 5's Physician's Order, with an order date of 8/21/2024, indicated to inhale (the process of drawing air into your lungs through your nose or mouth) Albuterol Sulfate (a medication used to prevent and treat difficulty breathing, wheezing [a symptom of a disease that obstructs the airways] and shortness of breath, coughing and chest tightness caused by lung diseases) five (5) milligrams (mg- unit of measure) 0.5% one inhalation orally via nebulizer every two hours as needed for dyspnea (difficulty breathing). During a concurrent observation and interview on 9/24/2024 at 9:00 a.m., with Licensed Vocational Nurse 1 (LVN 1), in Resident 5's room, observed that the mouthpiece and tubing of the HHN was stored (not in a bag and undated) inside Resident 5's nightstand, undated. LVN 1 stated that staff should have stored the mouthpiece and the tubing in a bag when not used for infection control. LVN 1 then stated that he (LVN 1) will discard the mouthpiece and tubing and provide a new mouthpiece and tubing for Resident 5. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Director of Nursing (DON) on 9/24/2024 at 9:45 a.m., the DON stated that the mouthpiece with tubing for a HHN should be stored in a bag after labeling with the date to prevent the spread of germs. The DON further stated that not storing in a bag was against the infection prevention control program. During a review of the facility's policy and procedure (P&P) titled, Administering Medications through a Small Volume (Handheld) Nebulizer last reviewed 7/30/2024, indicated, Rinse and disinfect the nebulizer equipment according to facility protocol, or: wash pieces with warm, soapy water When equipment is completely dry, store in a plastic bag with the resident's name and the date on it. Change equipment and tubing every seven days, or according to facility protocol. 2. During a review of Resident 2's Admission Record indicated the facility originally admitted Resident 2 on 6/8/2022 and readmitted on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD - a group of diseases that cause airflow blockage and breathing-related problems) and pruritis (medical term for itching, or the feeling on the skin that makes you want to scratch). During a review of Resident 2's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 7/2/2024, indicated Resident 2 was usually able to make self-understood and understand others. The MDS indicated that Resident 2 was dependent on staff for showers, toileting hygiene, and oral hygiene. During a concurrent observation and interview on 9/24/2024 at 8:37 a.m. with Treatment Nurse 1 (TN 1) and Resident 2, observed Resident 2's both hands had dry flaky skin and both palms were crusted. Resident 2 stated that his (Resident 2) skin was itchy, so he was scratching. When Resident 2 was asked how long his hands were dry and flaky, Resident 2 was unable to answer the question. TN 1 stated that there are no orders in place to address and treat Resident 2's dry flaky hands and crusted palms. TN 1 stated that he (TN 1) will immediately notify Resident 2's physician to obtain treatment. During a review of Resident 2's Physician Order dated 9/24/2024 timed 9:24 a.m., indicated, Stat (immediately) Skin scraping to rule out (r/o - a medical abbreviation that means a doctor is trying to eliminate a possible diagnosis or treatment for a resident) scabies. During a review of Resident 3's Admission Record indicated the facility originally admitted Resident 3 on 2/23/2024 and readmitted on [DATE] with diagnoses that included Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks) and type two diabetes mellitus (a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel). During a review of Resident 3's MDS dated [DATE], indicated Resident 3 was usually able to make self-understood and understand others. The MDS indicated that Resident 3 was dependent on staff for showers, needed maximum assistance for toileting hygiene, and moderate assistance for oral hygiene. During a concurrent observation and interview on 9/24/2024 at 8:50 a.m., with Certified Nursing Assistant 1 (CNA 1), in Resident 3's room, observed Resident 3 had dry flaky skin on the right palm. Resident 3 stated that her (Resident 3's) right palm was itchy. CNA 1 stated that changes in Resident 3's skin condition on the right palm was reported to TN 1 about two weeks ago (unable to recall specific date). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 3's Physician Order dated 9/24/2024, timed at 4:03 p.m. indicated to obtain a wound consult for Resident 3, and to administer Bactrim (used to treat a wide variety of bacterial infections) 800-160 mg one tablet by mouth two times a day for impetigo (an itchy, highly contagious skin infection). During a review of the facility's P&P titled, Infection Control last reviewed 7/30/2024, indicated, This facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections Prevent, detect, investigate, and control infections in the facility .establish guidelines for implementing isolation precautions, including standard and transmission-based precautions, During a review of the facility's P&P titled, Outbreak of Communicable Diseases last reviewed 7/30/2024, indicated, An outbreak is defined as one of the following: One case of an infection that is highly communicable or has serious health implications The administrator is responsible for communicating data about reportable diseases to the health department,