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	12/19/2024

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. 42275 Based on interview and record review, the facility failed to notify the physician and the resident's family regarding a skin discoloration on a resident's coccyx (tailbone) for one of three sampled residents (Resident 1). This deficient practice had the potential to negatively affect the delivery of care and services to Resident 1. Findings: During a review of Resident 1's Admission Record, the Admission Record indicated that the facility originally admitted the resident on 3/28/2022 and readmitted the resident on 10/6/2022 with diagnoses that included left hip fracture (broken bone) and presence of left artificial hip joint, osteoporosis (condition in which bones become weak and brittle), and diabetes mellitus (DM, a chronic [long-term] condition that affects the way the body processes blood glucose [sugar]). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 10/9/2022, the MDS indicated the resident's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was severely impaired. The MDS further indicated that the resident needed total assistance from staff with eating, oral hygiene, toilet hygiene, lower body dressing, bed mobility (movement), and transfer. During a review of Resident 1's Situation, Background, Assessment, Recommendation (SBAR, a communication tool used by healthcare workers to share information about a resident's condition to other members of the health care team, including a resident's physician) Communication Form dated 9/9/2022, the SBAR indicated that Resident 1's Certified Nursing Assistant (CNA) reported Resident 1's skin discoloration on the coccyx at 10:10 p.m., and zinc oxide (treats or prevents skin irritation like cuts, burns, or incontinent [loss of bowel or bladder control] brief rash) cream was applied and will continue to monitor resident. During a review of Resident 1's physician order dated 9/16/2022, the physician order indicated that Resident 1 had skin excoriation (a scrape or scratch to the skin) on buttocks, and to cleanse with normal saline (NS - a saltwater solution), pat dry, and apply zinc oxide every shift for 14 days. (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

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 12/18/2024 at 3:15 p.m., with Treatment Nurse 1 (TN 1), reviewed Resident 1's Departmental Notes (progress notes) for 9/2022, Resident 1's SBAR Communication Form dated 9/9/2022, and Resident 1's physician order dated 9/16/2022. TN 1 stated that the facility did not notify Resident 1's physician or family regarding Resident 1's skin discoloration on the coccyx noted on 9/9/2022. TN1 stated the first treatment order received on 9/16/2022 from Resident 1's physician to apply zinc oxide on Resident 1's buttocks on 9/16/2022, meant that Resident 1's physician was not notified until 9/16/2022. TN 1 stated that TN 1 was unable to locate documentation when Resident 1's family was notified regarding Resident 1's skin discoloration on the coccyx noted on 9/9/2022. TN 1 further stated that TN 1 was unsure how the facility did not notify Resident 1's physician and family regarding Resident 1's skin changes especially on the coccyx which could change to pressure ulcers (an injury that breaks down the skin and underlying tissue when an area of skin is placed under pressure) at any time. TN 1 stated that any changes of skin conditions should be notified to the residents' physician and family immediately. During a concurrent interview and record review on 12/19/2024 at 3:50 p.m., with the Director of Nursing (DON), reviewed Resident 1's Departmental Notes for 9/2022 and Resident 1's SBAR Communication Form dated 9/9/2022. The DON stated the DON was unable to locate documentation indicating the facility staff notified Resident 1's physician or family about Resident 1's skin discoloration on the coccyx reported to the licensed nurse by the CNA on 9/9/2022. The DON stated the facility staff should notify Resident 1's physician and family about Resident 1's skin discoloration on the coccyx on the same day, 9/9/2022. During a review of the facility's policy and procedure titled, Changes in a Resident's Conditions or Status, last reviewed on 7/30/2024, the policy 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 The nurse will notify the resident's attending physician or physician on call when there has been a (an) . need to alter the resident's medical treatment significantly a nurse will notify the resident's representative Except in medical emergencies, notification will be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 39550 Based on interview and record review, the facility failed to ensure a neurological assessment (evaluation of a person's nervous system [includes the brain, spinal cord, and a complex network of nerves]) was completed after an unwitnessed fall for one of three sampled residents (Resident 4). This deficient practice had the potential to result in confusion in the care and services for Resident 4, which could place the resident at risk of not receiving appropriate care due to incomplete resident medical care information. Findings: During a review of Resident 4's Admission Record, the Admission Record indicated the facility admitted the resident on 12/23/2023 and readmitted the resident on 3/11/2024 with diagnoses that included encephalopathy (any brain disease that alters brain function or structure), other lack of coordination, and schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 4's Minimum Data Set (MDS - a resident assessment tool) dated 9/11/2024, the MDS indicated Resident 4's cognitive skills (thought processes) for daily decision making was moderately impaired. The MDS indicated Resident 4 was independent with eating, oral hygiene, toileting hygiene, and personal hygiene. During a review of Resident 4's care plan (a document that summarizes a resident's needs, goals, and care/treatment) for risk for falls, initiated 9/11/2024, the care plan indicated interventions if fall occurs, initiate frequent neurological and bleeding evaluation per facility protocol. During a review of Resident 4's Situation, Background, Assessment, Recommendation (SBAR, a communication tool used by healthcare workers to share information about a resident's condition to other members of the health care team, including a resident's physician) Communication Form dated 12/15/2024, the SBAR Communication Form indicated that Resident 4 was found on the floor near the dietary department. During a concurrent interview and record review on 12/17/2024 at 4:02 p.m., with Licensed Vocational Nurse 1 (LVN 1), reviewed Resident 4's SBAR dated 12/15/2024 and Resident 4's Neurological Assessment Flow Sheet. LVN 1 stated that Resident 4 had an unwitnessed fall and was found near the dietary department. LVN 1 stated that after an unwitnessed fall licensed nurses will do a neurological assessment to monitor the resident's level of consciousness and monitor for any changes in condition (a sudden clinically important deviation from a resident's baseline in physical, cognitive, behavioral, or functional domains). LVN 1 further stated that if there are any changes noted, licensed nurses are to inform the doctor. LVN 1 reviewed Resident 4's Neurological Assessment Flow Sheet. LVN 1 stated that Resident 4's Neurological Assessment Flow Sheet was not complete. LVN 1 stated that there is no documented evidence that a neurological assessment was done on 12/16/2024 at 4:15 p.m. LVN 1 stated that neurological assessments are important to monitor residents after an unwitnessed fall, if any changes are noted licensed nurses would be able to inform the doctor for further interventions. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure titled, Neurological Assessment, reviewed 7/30/2024, the policy indicated the purpose of this procedure is to provide guidelines for neurological assessment: 1) upon physician order; 2) when following an unwitnessed fall; 3) subsequent to a fall with a suspected head injury; or 4) when indicated by resident condition. Under General Guidelines: 1. Neurological assessments are indicated: b. Following an unwitnessed fall. Documentation: The following information should be recorded in the resident's medical record: 1. The date and time the procedure was performed; 2. The name and title of the individual(s) who performed the procedure; 3. All assessment data obtained during the procedure; 4. How the resident tolerated the procedure; 5. If the resident refused the procedure, the reason(s) why and the interventions taken; 6. The signature and title of the person recording the data.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42275 Based on observation, interview, and record review, the facility failed to: 1. Ensure no more than two layers of linen were used with the use of a low air loss mattress (LALM - a specialty bed that alternates pressure to help heal and prevent pressure injuries [an injury that breaks down the skin and underlying tissue when an area of skin is placed under pressure]) for two of three sampled residents (Resident 2 and Resident 3). 2. Ensure the LALM was set to the correct setting as ordered for two of three sampled residents (Resident 2 and Resident 3). These deficient practices had the potential to increase the residents' risk of skin breakdown. Findings: a. During a review of Resident 2's Admission Record, the Admission Record indicated that the facility admitted the resident on 10/25/2023 with diagnoses that included gangrene (a serious medical condition where tissue dies due to a lack of blood supply) and dementia (a progressive state of decline in mental abilities). During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool) dated 10/17/2024, the MDS indicated the resident's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was severely impaired, and the resident needed total assistance from staff with toileting hygiene, personal hygiene, and transfer, and needed moderate assistance with bed mobility (movement). The MDS further indicated that Resident 2 was at risk of developing pressure ulcers/injuries (PU/PI). During a review of Resident 2's physician order dated 6/28/2024, the physician order indicated an order for a LALM with an alternating set mode (alternating air cells in the mattress are partially deflated and inflated, avoiding prolonged pressure on any single point) and setting based on comfort and/or of resident and check setting and functionality every shift for skin management. During a review of Resident 2's care plan (a document that summarizes a resident's needs, goals, and care/treatment) for at risk for skin breakdown initiated 11/23/2024, the care plan indicated a goal that the resident would have skin intact and no pressure ulcers or injuries. The care plan indicated an intervention to have a LALM as ordered. During a concurrent observation and interview on 12/17/2024 at 2:19 p.m., with Certified Nursing Assistant 1 (CNA 1), observed Resident 2 in bed on a LALM set to static mode (a setting that creates a firm surface) and lying on multiple layers consisting of one fitted sheet, one cloth incontinence (loss of bowel or bladder control) pad that is made of two different textures of linen, and wearing an adult brief. When CNA 1 was asked for the setting mode of Resident 2's LALM, CNA 1 stated that the CNAs should not touch the settings. When CNA 1 was asked about the linen use with a LALM, CNA 1 stated that only one sheet and a brief should be used, no more than that. CNA 1 stated CNA 1 forgot to remove the cloth incontinent pad that morning. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/18/2024 at 11:32 a.m., with Treatment Nurse 1 (TN 1), TN 1 stated that Resident 2 had a right heel surgical wound that resolved several months ago. TN 1 stated Resident 2's LALM was being used as a preventative method for skin management and the setting should be the alternating mode. TN 1 stated the CNAs should not use more than two layers of linen with the LALM. b. During a review of Resident 3's Admission Record, the Admission Record indicated that the facility originally admitted the resident on 9/3/2021 and readmitted the resident on 4/11/2024 with diagnoses that included chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing) and dementia. During a review of Resident 3's MDS dated [DATE], the MDS indicated the resident's cognitive skills for daily decision making was moderately impaired, and the resident needed total assistance from staff with toileting hygiene, lower body dressing, needed moderate assistance with transfer, and supervision or touching assistance with bed mobility. The MDS further indicated that Resident 3 was at risk of developing PU/PI. During a review of Resident 3's physician order dated 6/28/2024, the physician order indicated an order to apply LALM with an alternating set mode and setting based on comfort and/or of resident and check setting and functionality every shift for skin management. During a concurrent observation and interview on 12/17/2024 at 2:34 p.m., with CNA 2, observed Resident 3 in bed on a LALM set to static mode and lying on multiple layers of consisting of one fitted sheet, one cloth incontinence pad that is made of two different textures of linen, and wearing an adult brief. When CNA 2 was asked if the setting mode of the LALM was correct for Resident 3, CNA 2 stated that the CNAs do not touch the settings. When CNA 2 was asked about the linen use with a LALM, CNA 2 stated no more than two layers of linen should be used but forgot to remove the cloth incontinent pad and there was currently a total of four layers of linen. CNA 2 stated if more than two layers of linen are used, it was going to defeat the purpose of the LALM to prevent pressure ulcers. During an interview on 12/18/2024 at 11:38 a.m., with TN 1, TN 1 stated that Resident 3 did not ask to set the LALM to static mode, so the LALM should be set to alternating mode. TN 1 stated the CNAs should not use more than two layers of linen with the LALM. During a review of the facility's policy and procedure (P&P) titled, Prevention of Pressure Ulcers, last reviewed on 7/30/2024, the P&P indicated, Pressure ulcers are often made worse by continual pressure, heat, moisture, irritating substances on the resident's skin Determine if resident needs a special mattress per bed selection algorithm. During a review of the facility's P&P titled, Support Surface Guidelines, last reviewed 7/30/2024, the P&P indicated, Element of support surfaces that are critical to pressure ulcer prevention and general safety include pressure redistribution, moisture control, shear (to cut or slide something apart by applying force in opposite directions) reduction . and life expectancy. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility-provided Therapy Bed Training Checklist last reviewed on 7/30/2024, indicated, Static Button: Press the Static button to enter Static mode and maintain all air cushion in the mattress at a constant pressure Linen Protocol: The above support surfaces are provided with the manufacturers loose fitting top sheet that the resident may lay on directly. These top sheets are water resistance and preventing sheering and helps to control the skin micro climate therefore the least amount of linens are suggested. Plastic chucks (Chux) or plastic briefs should never be used Avoid the multiple layers of linen under the resident. A single cotton draw sheet for turning and to absorb incontinence.

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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 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 39550 Based on observation, interview, and record review, the facility failed to ensure staffing information of the actual hours worked by licensed and unlicensed nursing staffing directly responsible for resident care per shift was posted daily for two of two days on 12/17/2024 and on 12/18/2024. This deficient practice had the potential to keep residents and visitors unaware of the total number of staff and the actual hours worked by staff in the facility. Findings: During an observation on 12/17/2024 at 3:00 p.m., observed in the facility's lobby, a facility document titled, Posted Nursing Hours for Direct Care Staff, dated 12/17/2024. During an interview on 12/17/2024 at 4:28 p.m., with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated that nursing hours posted in the lobby are projected (expected) hours. During a concurrent observation, interview, and record review on 12/17/2024 at 5:06 p.m., with the Director of Nursing (DON), observed the facility's document titled, Posted Nursing Hours for Direct Care Staff, dated 12/17/2024, posted in the facility's lobby. The DON stated that the posted document is the facility's nursing projected hours. During an interview on 12/18/2024 at 12:42 p.m., with Payroll 1, Payroll 1 stated that Payroll 1 is responsible for calculating the facility's actual nursing hours worked daily. Payroll 1 stated that actual nursing hours are calculated the following day for the day prior to ensure that the nursing hours are calculated accurately. Payroll 1 stated that the daily nursing hours posted in the lobby are projected nursing hours for the current day, not actual hours. During a follow-up interview on 12/18/2024 at 1:06 p.m., with Payroll 1, Payroll 1 stated that Payroll 1 has not calculated the actual nursing hours for direct care staff for 12/17/2024 and 12/18/2024. Payroll 1 stated that 12/18/2024's actual nursing hours will be calculated tomorrow, 12/19/2024. During an interview on 12/18/2024 at 1:09 p.m., with the DON, the DON stated that the nursing hours should be calculated daily. The DON stated that today's (12/18/2024) nursing hours will be calculated tomorrow. The DON further stated that the DON does not deal with posted nursing hours and just signs them the following day. During a concurrent observation, interview, and record review on 12/18/2024 at 1:20 p.m., with the DON, observed the facility's document titled, Posted Nursing Hours for Direct Care Staff, dated 12/18/2024, posted in the facility's lobby. The DON stated that the posted document is the facility's nursing projected hours, not actual hours. The DON stated that it is important to post nursing hours because it will show staff, visitors, and residents that the facility is well staffed. (continued on next page)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility-provided policy titled, Nurse Staffing Information, reviewed 7/30/2024, the policy indicated the facility will post on a daily basis for each shift nurse staffing data, including the number of nursing personnel responsible for providing direct care to residents. The information recorded on the form shall include the following: a. The name of the facility; b. The current date (the date for which the information is posted); c. The resident census at the beginning of the shift for which the information is posted; d. Twenty-four (24)-hour shift schedule operated by the facility; e. The shift for which the information is posted; e. Type (RN [Registered Nurse], LVN [Licensed Vocational Nurse], or CNA [Certified Nursing Assistant]) and category (licensed or non-licensed) of nursing staff working during that shift who are paid by the facility (including contract staff); g. the actual time worked during that shift for each category and type of nursing staff; and h. Total number of licensed and non- licensed nursing staff working for the posed shift. Within two (2) hours of the beginning of each shift, the charge nurse or designee computes the number of direct care staff and completed the Nurse Staffing Information form. The charge nurse completes the form and posts the staffing information in the location(s) designated by the administrator.

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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. 42275 Based on interview and record review, the facility failed to obtain a physician's order prior to applying zinc oxide (treats or prevents skin irritation like cuts, burns, or incontinent [loss of bowel or bladder control] brief rash) cream for one of three sampled residents (Resident 1). This deficient practice had the potential to negatively affect the delivery of care and services. Findings: During a review of Resident 1's Admission Record, the Admission Record indicated that the facility originally admitted the resident on 3/28/2022 and readmitted the resident on 10/6/2022 with diagnoses that included left hip fracture (broken bone) and presence of left artificial hip joint, osteoporosis (condition in which bones become weak and brittle), and diabetes mellitus (DM, a chronic [long-term] condition that affects the way the body processes blood glucose [sugar]). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 10/9/2022, the MDS indicated the resident's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was severely impaired. The MDS further indicated that the resident needed total assistance from staff with eating, oral hygiene, toilet hygiene, lower body dressing, bed mobility (movement), and transfer. During a review of Resident 1's Situation, Background, Assessment, Recommendation (SBAR, a communication tool used by healthcare workers to share information about a resident's condition to other members of the health care team, including a resident's physician) Communication Form dated 9/9/2022, the SBAR indicated that Resident 1's Certified Nursing Assistant (CNA) reported Resident 1's skin discoloration on the coccyx at 10:10 p.m., and zinc oxide cream was applied and will continue to monitor resident. During a review of Resident 1's physician order dated 9/16/2022, the physician order indicated that Resident 1 had skin excoriation (a scrape or scratch to the skin) on buttocks, and to cleanse with normal saline (NS - a saltwater solution), pat dry, and apply zinc oxide every shift for 14 days. During a concurrent interview and record review on 12/18/2024 at 4:25 p.m., with Treatment Nurse 1 (TN 1), reviewed Resident 1's SBAR Communication Form dated 9/9/2022 and physician order dated 9/16/2022 to apply zinc oxide cream to Resident 1's skin excoriation on buttocks. TN 1 stated that there was no physician's order to apply zinc oxide cream until 9/16/2022, so the staff should not apply zinc oxide cream without obtaining the physician order on 9/9/2022. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 12/19/2024 at 3:50 p.m., with the Director of Nursing (DON), reviewed Resident 1's Departmental Notes (progress notes) for 9/2022 and Resident 1's SBAR Communication Form dated 9/9/2022. The DON stated the DON was unable to locate documentation indicating the facility staff notified Resident 1's physician or family about Resident 1's skin discoloration on the coccyx reported to the licensed nurse by the CNA on 9/9/2022. The DON stated there was no physician order to apply zinc oxide cream on Resident 1's coccyx on 9/9/2022 and the nursing staff should not apply the medication without the physician's order. During a review of the facility's policy and procedure titled, Medication and Treatment Orders, last reviewed on 7/30/2024, the policy indicated, Orders for medications and treatments will be consistent with principles of safe and effective order writing Medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state. Only authorized, licensed practitioners, or individuals authorized to take verbal orders from practitioners, shall be allowed to write orders in the medical record.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42275 Based on interview and record review, the facility failed to ensure a resident was free of unnecessary psychotropic drugs (medications capable of affecting the mind, emotions, and behavior) for one of three sampled residents (Resident 1) by failing to summarize a resident's monthly behavior and side effects summary. This deficient practice had the potential to result in the resident receiving unnecessary psychotropic drugs potentially increasing Resident 1's risk of adverse reactions (undesired harmful effect resulting from a medication or other intervention). Findings: During a review of Resident 1's Admission Record, the Admission Record indicated that the facility originally admitted the resident on 3/28/2022 and readmitted the resident on 10/6/2022 with diagnoses that included left hip fracture (broken bone) and presence of left artificial hip joint, schizoaffective disorder (a mental health condition that includes features of both schizophrenia [serious mental illness that affects how a person thinks, feels, and behaves] and a mood disorder [marked disruptions in emotions]), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 10/9/2022, the MDS indicated the resident's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was severely impaired. The MDS further indicated that the resident needed total assistance from staff with eating, oral hygiene, toilet hygiene, lower body dressing, bed mobility (movement), and transfer. During a review of Resident 1's physician orders dated 10/6/2022, the physician orders indicated the following: - Trazodone (medication used to treat depression) 50 milligrams (mg - a unit of measurement), give one tablet by mouth daily at bedtime for depression. - Risperdal (medication used to treat schizophrenia) 0.5 mg, give one tablet by mouth every 12 hours daily for schizoaffective disorder. During a review of Resident 1's undated Behavior Summary Side Effects form for Trazodone 50 mg, the Behavior Summary Side Effects form was blank and did not indicate the number of episodes of verbalization of sadness for Trazodone and did not indicate the number of adverse reactions for 10/2022 and 11/2022. (continued on next page)

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	555578	A. Building B. Wing	12/19/2024

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

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 1's undated Behavior Summary Side Effects form for Risperdal 0.5 mg, the Behavior Summary Side Effects form was blank and did not indicate the number of episodes of striking out at staff for Risperdal and did not indicate the number of adverse reactions for 10/2022 and 11/2022. During a concurrent interview and record review on 12/18/2024 at 12:05 p.m., with Licensed Vocational Nurse 1 (LVN 1), reviewed Resident 1's undated Behavior Summary Side Effects form for Trazodone 50 mg and Risperdal 0.5 mg. LVN 1 stated that the facility did not summarize the monthly Behavior Summary Side Effects for both medications, Trazodone and Risperdal, for 10/2022 and 11/2022 and stated it should have been completed. LVN 1 stated the facility would not be able to compare the psychotropic medications' effectiveness or side effects that occurred from month to month without monthly summary data. During a concurrent interview and record review on 12/19/2024 at 4:10 p.m., with the Director of Nursing (DON), reviewed Resident 1's undated Behavior Summary Side Effects form for Trazodone 50 mg and Risperdal 0.5 mg. The DON stated that the facility did not document monthly behavior data since being readmitted on [DATE]. The DON stated without a monthly summary of the behavioral or mood episodes for residents with psychotropic medications, it would be hard to proceed with a gradual dose reduction (GDR - the stepwise reducing of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued) or to evaluate the effectiveness of psychotropic medications. During a review of the facility's policy and procedure (P&P) titled, Psychotropic Medication Use, last reviewed on 7/30/2024, the policy indicated, Residents will not receive medications that are not clinically indicated to treat a specific condition . Consideration of the use of any psychotropic medication is based on comprehensive review of the resident. This includes evaluation of the resident's signs and symptoms in order to identify underlying causes If psychotropic medications are identified as possibly causing or contributing to adverse consequences, the prescriber will determine whether the medication(s) should be continued and document the rationale for this decision. During a review of the facility's P&P titled, Pharmaceutical Services Policy and Procedure Manual, last reviewed on 7/30/2024, the policy indicated, The facility shall utilize the data presented by the consultant pharmacist (and others) to formulate and monitor psychoactive drug use improvement plans.

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F 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results. 39550 Based on interview and record review, the facility failed to promptly notify the physician of the results of a Stat (without delay, immediately) X-ray (a type of medical imaging that uses radiation to take pictures of the inside of your body) for one of three sampled residents (Resident 1). This deficient practice resulted in the delay of necessary care and services for Resident 1. Findings: During a review of Resident 1's Admission Record, the Admission Record indicated that the facility originally admitted the resident on 3/28/2022 and readmitted the resident on 10/6/2022 with diagnoses that included left hip fracture (broken bone) and presence of left artificial hip joint, osteoporosis (condition in which bones become weak and brittle), and diabetes mellitus (DM, a chronic [long-term] condition that affects the way the body processes blood glucose [sugar]). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 10/9/2022, the MDS indicated the resident's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was severely impaired. The MDS further indicated that the resident needed total assistance from staff with eating, oral hygiene, toilet hygiene, lower body dressing, bed mobility (movement), and transfer. During a review of Resident 1's Situation, Background, Assessment, Recommendation (SBAR, a communication tool used by healthcare workers to share information about a resident's condition to other members of the health care team, including a resident's physician) Communication Form dated 9/29/2022, the SBAR Communication Form indicated that Resident 1's skin is intact with redness to upper leg noted after Resident 1 slid from the chair. STAT (immediately) X-ray ordered. During a review of Resident 1's physician order dated 9/29/2022 at 7:38 p.m., the physician order indicated an order for X-ray to left hip, left femur (thigh bone) to rule out fracture. During a review of Resident 1's document titled, Portable Service Requisition, dated 9/29/2022, the document indicated a STAT X-ray to be done for Resident 1's left hip and left femur. The document indicated under exam tracking information: Arrival date/time: 9/29/2022 at 11:22 p.m. During a concurrent interview and record review on 12/19/2024 at 9:45 a.m., with Licensed Vocational Nurse 1 (LVN 1), reviewed Resident 1's SBAR dated 9/29/2022, Resident 1's physician's orders, and Resident 1's nursing progress notes from 9/29/2022-9/30/2022. LVN 1 stated that Resident 1 had a fall incident on 9/29/2022 and STAT X-rays were ordered. LVN 1 stated that on 9/29/2022 at 7:38 p.m., Resident 1's physician ordered a STAT X-ray of Resident 1's left hip. LVN 1 stated that on 9/30/2022 at 7:35 a.m., there is documentation that X-ray results were relayed to Resident 1's physician and Resident 1 was ordered to be transferred to the hospital for further evaluation of left hip fracture. (continued on next page)

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F 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow-up concurrent interview and record review on 12/19/2024 at 11:26 a.m., with LVN 1, reviewed the facility record titled, MediMatrix, dated 9/29/2022-9/30/2022 from the mobile diagnostic company. LVN 1 stated that the mobile diagnostic company emailed Resident 1's X-ray results on 9/30/2022 at 12:53 a.m.; called the facility, no answer on 9/30/2022 at 12:55 a.m.; called the facility, no answer on 9/30/2022 at 5:04 a.m.; called the facility, no answer on 9/30/2022 at 6:56 a.m.; called the facility, no answer on 9/30/2022 at 7:08 a.m. During a concurrent interview and record review on 12/19/2024 at 12:46 p.m., with the Medical Records Director (MRD), reviewed the email correspondence from the mobile diagnostic company and the facility. The MRD stated that the facility received Resident 1's X-ray results via email on 9/30/2022 at 12:50 a.m. and on 9/30/2022 at 6:57 a.m. The MRD stated that the MRD does not know why the results were emailed to the Director of Nursing at that time. During a follow-up interview on 12/19/2024 at 3:03 p.m., with LVN 1, LVN 1 stated that there should have been a better endorsement process between nursing staff from the 3 p.m.-11 p.m. and 11 p.m.-7 a.m. shift. LVN 1 continued to state that because the X-ray order was a STAT order, the 9/29/2022 11 p.m.-7 a.m. shift licensed nurses should have followed up the results of the STAT X-ray order and should have documented their attempts. During an interview on 12/19/2024 at 4:32 p.m., with the Director of Nursing (DON), the DON stated that the incident that happened with Resident 1 was before the DON's time in the facility. The DON stated that facility staff should have followed up and called the diagnostic company for results sooner to avoid the delay of care. During a review of the facility-provided policy and procedure titled, Lab and Diagnostic Test Results-Clinical Protocol, reviewed 7/30/2024, the policy indicated when test results are reported to the facility, a nurse will first review the results. If staff who first receive or review lab and diagnostic test results cannot follow the remainder of this procedure for reporting and documenting the results and their implications, another nurse in the facility should follow or coordinate the procedure .A nurse will identify the urgency of communicating with the Attending Physician based on physician request, the seriousness of any abnormality, and the individual's current condition .nursing staff will consider the following factors to help identify situations requiring prompt physician notification concerning lab or diagnostic test results: a. Whether the physician has requested to be notified as soon as a result is received. b. Whether the result should be conveyed to a physician regardless of other circumstances (that is, the abnormal result is problematic of any other factors). c. Whether the resident/patient's clinical status is unclear or he/she has signs and symptoms of acute (sudden) illness or condition change and is not stable or improving, or there are no previous results for comparison.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 42275 Based on interview and record review, the facility failed to maintain complete and accurate medical records in accordance with accepted professional standards for one of three sampled residents (Resident 1), by failing to document on a resident's Activities of Daily Living (ADL - activities related to personal care) Flow Sheet. This deficient practice resulted in incomplete resident medical care information for Resident 1 and had the potential to result in confusion with the care and services for Resident 1 which could place the resident at risk for not receiving appropriate care. Findings: During a review of Resident 1's Admission Record, the Admission Record indicated that the facility originally admitted the resident on 3/28/2022 and readmitted the resident on 10/6/2022 with diagnoses that included left hip fracture (broken bone) and presence of left artificial hip joint, osteoporosis (condition in which bones become weak and brittle), and diabetes mellitus (DM, a chronic [long-term] condition that affects the way the body processes blood glucose [sugar]). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 10/9/2022, the MDS indicated the resident's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was severely impaired. The MDS further indicated that the resident needed total assistance from staff with eating, oral hygiene, toilet hygiene, lower body dressing, bed mobility (movement), and transfer. During a review of Resident 1's ADL Flow Sheet for 12/2022, the ADL Flow Sheet indicated there were no documented entries (blank) to indicate the care and services were provided or refused by Resident 1 on the following self-care areas and mobility areas as follows: - On 12/9/2022, 7 a.m. to 3 p.m., bowel function, personal hygiene, and bathing was left blank. - On 12/10/2022, 3 p.m. to 11 p.m., transfer and locomotion off unit (how resident moves to/return from off-unit [areas set aside for dining, activities or treatments] locations) was left blank. - On 12/15/2022, 3 p.m. to 11 p.m., nail care needed or not, bed mobility, transfer, walk in room/corridor, locomotion on unit, dressing, eating, bladder function, and bowel function was left blank. - On 12/16/2022, 7 a.m. to 3 p.m., locomotion on/off unit was left blank. - On 12/21/2022, 7 a.m. to 3 p.m., nail care needed or not, bed mobility, transfer, walk in room/corridor, locomotion on/off unit, dressing, eating, meal percentage consumed for breakfast, toilet use, bladder/bowel function, personal hygiene, and bathing was left blank. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 1's ADL Flow Sheet further indicated that there were no assigned Certified Nursing Assistants' (CNA) initials on 12/9/2022 7 a.m. to 3 p.m., 12/12/2022 3 p.m. to 11 p.m., 12/15/2022 3 p.m. to 11 p.m., and 12/21/2022 7 a.m. to 3 p.m. During a concurrent interview and record review on 12/19/2024 at 9:57 a.m., with Certified Nursing Assistant 3 (CNA 3), reviewed Resident 1's ADL Flow Sheet for 12/2022. CNA 3 stated the CNAs should document at the end of their shift for the services provided to the residents and stated it was very important to document correctly. CNA 3 stated if they did not document, then they could not say what services were provided to the residents, and without the CNA's initials, they would not know who provided the services to the resident. During a concurrent interview and record review on 12/19/2024 at 4:15 p.m., with the Director of Nursing (DON), reviewed Resident 1's ADL Flow Sheet for 12/2022. The DON stated that there were gaps on Resident 1's ADL Flow Sheet, and the CNAs did not document what services were provided to Resident 1. The DON further stated that no documentation meant no services were done, or they are unable to tell how the residents were doing with their ADLs. The DON stated that is why the CNAs should not miss their documentation on the residents' ADL Flow Sheet. During a review of the facility's policy and procedure titled, Charting and Documentation, last reviewed on 7/30/2024, the policy indicated, All services are provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the residence medical record. The medical record should facilitate the communication between the interdisciplinary team (IDT, a group of health care professionals with various areas of expertise who work together toward the goals of the residents' care plan) regarding the resident's condition and response to care Documentation of procedures and treatments will include care-specific details including the date and time the procedure/treatment was provided; the name and title of the individual(s) who provided the care the signature and title of the individual documenting.