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	04/10/2026

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident's call light (a device used by a resident to signal his/her need for assistance from staff) was within reach for one of three sampled residents (Resident 1).This deficient practice had the potential to delay staff response and result in unmet resident needs. During a review of Resident 1's admission Record, the admission Record indicated that the facility originally admitted Resident 1 on 2/20/2026 and readmitted on [DATE] with diagnoses that included diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing), hemiplegia (total paralysis [loss of ability to move part or all of the body] of the arm, leg, and trunk on the same side of the body) and hemiparesis (paralysis or weakness on one side of the body) following cerebral infarction (known as stroke, loss of blood flow to a part of the brain resulting in damage to brain tissue), chronic kidney disease (a long-term condition where the kidneys are damaged and cannot effectively filter waste and extra fluid from the blood), and psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality).During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 2/24/2026, the MDS indicated that Resident 1's cognition (ability to think, reason, and function) was intact. The MDS indicated that Resident 1 required moderate assistance from staff with oral care, toileting, personal hygiene, showering, lower body dressing, bed mobility (movement), and transfers for chair/bed-to-chair and toilet. The MDS further indicated that Resident 1 was independent with eating.During a review of Resident 1's Situation-Background-Assessment-Recommendation (SBAR - a communication tool used by healthcare workers when there is a change of condition among the residents) Communication form dated 3/25/2026, timed at 3:08 p.m., the SBAR indicated that Resident 1 fell in the bathroom, as reported by Resident 1's family. The SBAR indicated that two staff members assisted Resident 1 back to bed following the incident.During a review of Resident 1's untitled care plan report initiated on 4/1/2026, the care plan report indicated Resident 1 had activities of daily living (ADLs- activities such as bathing, dressing and toileting performed daily) deficits. The care plan report indicated an intervention to ensure the call light was within reach and that staff responded promptly to resident calls/requests. During a concurrent observation and interview on 4/9/2026 at 1:09 p.m., with Resident 1 and Certified Nursing Assistant 1 (CNA 1), in Resident 1's room, it was observed that Resident 1 was sitting on the resident bed, and Resident 1's call light cord and button were hanging over the bulletin board located under Resident 1's overhead wall-mounted lamp. Resident 1 stated that the call light should be within reach; however, Resident 1 was unable to access Resident 1's call light and could not see where it was. Resident 1 further stated that staff assistance could not be obtained if needed at that time. CNA 1 stated that if Resident 1 is unable to reach the call light when needed, Resident 1 may attempt to move without assistance, which could result in a potential fall incident. CNA 1 further stated that the resident's call light should be kept within reach at all times. During an interview on 4/10/2026 at 4:23 p.m., with the Director of Nursing (DON), the DON stated that Resident 1 had one documented fall incident since the initial admission. The DON further stated that the call light should be kept within the resident's reach at all times, as failure to do so may result in Resident (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1 attempting to move without assistance, increasing the risk for falls. During a review of the facility's policy and procedures (P&P) titled, Answering the Call Light last reviewed on 1/28/2026, the P&P indicated, The purpose of this procedure is to ensure timely responses to the resident's requests and needs. Ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on interview and record review, the facility failed to notify a physician for one of three sampled residents (Resident 1) regarding the following:1. Resident 1's elevated blood sugar (BS) levels greater than 200 milligrams per deciliter (mg/dl - unit of measurement) per the physician orders.2. Resident 1's refusal to undergo a complete blood count (CBC - an essential blood test that measures the cells circulating in the blood, including the red blood cells [oxygen transport], white blood cells [infection fighting], and platelets [clotting], used to evaluate overall health and diagnose medical conditions) for anemia (a condition in which the body lacks sufficient healthy red blood cells) on 4/6/2026.These deficient practices may result in worsening symptoms, increased risk of hospitalization or complications and a decline in the resident's overall health status. During a review of Resident 1's admission Record, the admission Record indicated that the facility originally admitted Resident 1 on 2/20/2026 and readmitted on [DATE] with diagnoses that included diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing), hemiplegia (total paralysis [loss of ability to move part or all of the body] of the arm, leg, and trunk on the same side of the body) and hemiparesis (paralysis or weakness on one side of the body) following cerebral infarction (known as stroke, loss of blood flow to a part of the brain resulting in damage to brain tissue), chronic kidney disease (a long-term condition where the kidneys are damaged and cannot effectively filter waste and extra fluid from the blood), and psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality).During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 2/24/2026, the MDS indicated that Resident 1's cognition (ability to think, reason, and function) was intact. The MDS indicated that Resident 1 required moderate assistance from staff with oral care, toileting, personal hygiene, showering, lower body dressing, bed mobility (movement), and transfers for chair/bed-to-chair and toilet. The MDS further indicated that Resident 1 was independent with eating.1. During a review of Resident 1's Order Summary Report, the Order Summary Report indicated a Physician Order dated 4/1/2026 (to start on 4/2/2026) for BS check two times a day for diabetes mellitus (DM - a disorder characterized by difficulty in BS control and poor wound healing) before breakfast and before dinner, with instructions to notify the physician when BS levels exceeded 200 mg/dl. During a review of Resident 1's Medication Administration Record (MAR - a report detailing the medications administered to a resident by a healthcare professional at a facility) for 4/2026, the MAR indicated that licensed nurses documented BS checks at 6:30 a.m. and 4:30 p.m. The MAR indicated multiple instances in which Resident 1's BS levels exceeded 200 mg/dl, as follows: 4/2/26 at 4:30 p.m. BS was 239. 4/3/26 at 4:30 p.m. BS was 498. 4/4/26 at 4:30 p.m. BS was 205. 4/5/26 at 6:30 a.m. BS was 226, and at 4:30 p.m. BS was 389.During a concurrent interview and record review on 4/10/2026 at 1:30 p.m., with Registered Nurse 4 (RN 4), Resident 1's Physician Order dated 4/1/2026 (to start on 4/2/2026) and MAR for 4/2026 were reviewed. RN 4 reviewed Resident 1's progress notes from 4/2/2026 to 4/5/2026 and stated that RN 4 was unable to locate documentation indicating that licensed nurses notified the physician regarding elevated BS readings greater than 200 mg/dl obtained before meals. RN 4 further stated that it is important to notify the physician of elevated BS results, as the physician may adjust the treatment plan, including modifications to insulin (a hormone that helps regulate blood sugar levels) dosages. During a concurrent interview and record review on 4/10/2026 at 3:30 p.m., with RN 3, Resident 1's Physician Order dated 4/1/2026 (to start on 4/2/2026) and MAR for 4/2026 were reviewed. RN 3 stated that RN 3 documented Resident 1's BS as 239 on 4/2/2026 at 4:30 p.m. and 498 on 4/3/2026 at 4:30 p.m. RN 3 stated that the physician was not notified regarding BS levels greater than 200 mg/dl and stated that RN 3 was unable to locate documentation indicating that other licensed nurses had notified the physician either. During a concurrent interview and record review on (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4/10/2026 at 4:23 p.m., with the Director of Nursing (DON), Resident 1's Physician Order dated 4/1/2026, MAR for 4/2026, and BS summaries since the original admission on [DATE] were reviewed. The DON stated that licensed nurses should notify the physician of elevated BS levels greater than 200 mg/dl regardless of whether the BS checks are completed before or after meals. The DON further stated that licensed nurses are responsible for reporting elevated BS levels along with the resident's current anti-hyperglycemic medications (used to treat DM by lowering BS levels) so the physician can determine whether changes to the plan of care are necessary to control the resident's BS.2. During a review of Resident 1's Order Summary Report, the Order Summary Report indicated a Physician Order dated 4/1/2026 (to start on 4/6/2026) for CBC to be completed every Monday day shift for anemia. During a concurrent interview and record review on 4/10/2026 at 2:19 p.m., with Licensed Vocational Nurse 1 (LVN 1), Resident 1's Physician Order to check CBC every Monday for anemia and Resident 1's test request form dated 4/6/2026 were reviewed. LVN 1 reviewed Resident 1's progress notes from 4/1/2026 to 4/10/2026 and stated that LVN 1 did not notify the physician on 4/6/2026 regarding Resident 1's refusal to check the CBC and that the physician was not notified until 4/8/2026. LVN 1 reviewed General Acute Care Hospital 1 (GACH 1) History and Physical (H&P) Report dated 3/27/2026 and stated that GACH 1's H&P Report indicated Resident 1 had a history of bleeding with low hemoglobin (an iron-rich protein found in red blood cells that transport oxygen from the lungs to the body's tissues and returns carbon dioxide from tissues back to the lungs) when transferred to the hospital on 3/26/2026. LVN 1 stated that LVN 1 should have notified the physician immediately on 4/6/2026 regarding Resident 1's refusal to complete the CBC, as this was the responsibility of licensed nursing staff. During a concurrent interview and record review on 4/10/2026 at 3:57 p.m., with the Director of Nursing (DON), Resident 1's Physician Order to check CBC every Monday for anemia was reviewed. The DON stated that the licensed nurse should have notified the physician immediately when Resident 1 refused the CBC on 4/6/2026 and should not have delayed notification until 4/8/2026.During a review of the facility's policy and procedures (P&P) titled Change in a Resident's Condition or Status last reviewed on 1/28/2026, the P&P 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 (e.g., changes in level of care, billing/payments, resident rights, etc.) . The nurse will notify the resident's attending physician or physician on call when there has been a(an). Refusal of treatment or medications two (2) or more consecutive times. specific instruction to notify the physician of changes in the resident's condition. The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status.During a review of the facility's P&P titled, Diabetes - Clinical Protocol last reviewed on 1/28/2026, the P&P indicated, The physician will order desired parameters for monitoring and reporting information related to blood sugar management. The staff will incorporate such parameters into Medication Administration Record and care plan.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility licensed nurses failed to accurately assess and complete fall risk evaluations for two of three sampled residents (Resident 1 and Resident 2).These deficient practices had the potential to place the residents at increased risk for injury related to falls.a. During a review of Resident 1's admission Record, the admission Record indicated that the facility originally admitted Resident 1 on 2/20/2026 and readmitted on [DATE] with diagnoses that included diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing), hemiplegia (total paralysis [loss of ability to move part or all of the body] of the arm, leg, and trunk on the same side of the body) and hemiparesis (paralysis or weakness on one side of the body) following cerebral infarction (known as stroke, loss of blood flow to a part of the brain resulting in damage to brain tissue), chronic kidney disease (a long-term condition where the kidneys are damaged and cannot effectively filter waste and extra fluid from the blood), and psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality).During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 2/24/2026, the MDS indicated that Resident 1's cognition (ability to think, reason, and function) was intact. The MDS indicated that Resident 1 required moderate assistance from staff with oral care, toileting, personal hygiene, showering, lower body dressing, bed mobility (movement), and transfers for chair/bed-to-chair and toilet. The MDS further indicated that Resident 1 was independent with eating.During a review of Resident 1's Fall Risk Evaluation dated 2/20/2026, the Fall Risk Evaluation indicated the following:1. History, Current Status, Predisposing Conditions Section. This section indicated to conduct assessment upon admission and quarterly, at a minimum, thereafter, observe the resident status in the 11 clinical condition parameters listed below by assigning the corresponding score which best describes the resident. If the total score is 10 or greater, the resident should be considered at high risk for potential falls. Prevention protocol should be initiated immediately and documented on the care plan. However, systolic blood pressure (the top [higher] number in a blood pressure reading, measuring the maximum pressure in your arteries when the heart contracts and pumps blood) was not marked, and several items were left blank. 2. Gait (a person's particular manner, style, or pattern of walking or running) and Balance Section. This section requires observation of the resident's gait and balance, including having the resident stand on both feet without holding onto anything, if safe to do so. If assistive devices are required, provide the device and then proceed. Walk straight forward; walk through a doorway; and make a turn. No items were marked that best describes the resident abilities, including the option not able to perform function. 3. Medications Section. This section requires documentation of medications associated with fall risk or selection of none if applicable. No items were marked, including none of these medications taken currently or within the last seven (7) days.During a review of Resident 1's Fall Risk Evaluation dated 2/20/2026, the Fall Risk Evaluation indicated that the evaluation was in progress with a total fall score of eight (indicating the resident was not considered at high risk for potential falls).During a concurrent interview and record review on 4/9/2026 at 1:52 p.m., with Medical Records Assistant 1 (MRA 1), Resident 1's Fall Risk Evaluation dated 2/20/2026 was reviewed. MRA 1 stated that Resident 1's Fall Risk Evaluation dated 2/20/2026 was incomplete, which is why it remained marked as in progress.During a review of Resident 1's Situation-Background-Assessment-Recommendation (SBAR - a communication tool used by healthcare workers when there is a change of condition among the residents) Communication form dated 3/25/2026, timed at 3:08 p.m., the SBAR indicated that Resident 1 fell in the bathroom, as reported by Resident 1's family. The SBAR indicated that two staff members assisted Resident 1 back to bed following the incident.During a review of Resident 1's Fall Risk Evaluation dated 3/25/2026, the Fall Risk Evaluation indicated the following:1. History, Current (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Status, and Predisposing Conditions Section. History of falls (past three [3] months) was marked as no falls in the past three (3) months despite SBAR (dated 3/25/2026) documentation of a fall on the same date. Vision status was not marked, with items left blank. Predisposing disease was marked for none present.During a review of Resident 1's Fall Risk Evaluation dated 3/25/2026, the Fall Risk Evaluation indicated a fall score of five (indicating the resident was not considered at high risk for potential falls).During a concurrent interview and record review on 4/9/2026 at 1:42 p.m., with Registered Nurse 1 (RN 1), Resident 1's Fall Risk Evaluation dated 3/25/2026 was reviewed. RN 1 stated that RN 1 performed Resident 1's Fall Risk Evaluation after the fall incident occurred on 3/25/2026. However, RN 1 did not include the actual fall incident that occurred on 3/25/2026 when responding to the question regarding history of falls in the past three (3) months. RN 1 stated that she (RN 1) left the vision status section blank and marked none present for predisposing disease because RN 1 did not see the diagnosis of cerebrovascular accident (CVA - known as stroke, loss of blood flow to a part of the brain). RN 1 further stated that the Fall Risk Evaluation for Resident 1 was incomplete.During a further interview and record review on 4/9/2026 at 2:41 p.m., with RN 1, when RN 1 was asked why the Fall Risk Evaluations should be completed correctly, RN1 stated that accurate completion is necessary to identify residents at high risk for falls and to ensure appropriate interventions are implemented to reduce fall risk based on the evaluation results. b. During a review of Resident 2's admission Record, the admission Record indicated that the facility originally admitted Resident 2 on 1/21/2024 and readmitted on [DATE] with diagnoses that included pneumonitis (swelling and irritation of the lung tissue), DM, Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities), and anemia (a condition where the body does not have enough healthy red blood cells).During a review of Resident 2's MDS dated [DATE], the MDS indicated that Resident 2's cognition was severely impaired, and Resident 2 required moderate assistance from staff with oral care, toileting, personal hygiene, showering, lower body dressing, and toilet transfer. The MDS further indicated Resident 2 required supervision or touching assistance for bed mobility (movement), and transfers between bed and chair.During a review of Resident 2's Fall Risk Evaluation dated 2/21/2026, the Fall Risk Evaluation indicated the following:1. Medications Section. No items were marked, including the option none of these medications taken currently or within the last seven (7) days.During a review of Resident 2's Fall Risk Evaluation dated 2/21/2026, the Fall Risk Evaluation indicated a fall score of 12.During a review of Resident 2's Fall Risk Evaluation dated 3/29/2026, the Fall Risk Evaluation indicated the following:2. Gait and Balance Section. No items were marked, including the option not able to perform function. 3. Medication Section. No items were marked, including the option none of these medications taken currently or within last seven (7) days.During a review of Resident 2's Fall Risk Evaluation dated 3/29/2026, the Fall Risk Evaluation indicated a fall score of 10 (indicating the resident was not considered at high risk for potential falls).During a concurrent interview and record review on 4/9/2026 at 4:40 p.m., with RN 2, Resident 2's Fall Risk Evaluations dated 2/21/2026 and 3/29/2026 were reviewed. RN 2 stated that the Fall Risk Evaluations were not completed accurately. RN 2 stated that it was very important to complete the Fall Risk Evaluations with correct and complete information to be able to implement appropriate interventions aimed at preventing or reducing fall risks.During an interview on 4/10/2026 at 3:49 p.m., with the Director of Nursing (DON), the DON stated that licensed nurses should complete the Fall Risk Evaluations accurately and thoroughly to properly assess the resident's risk for falls. The DON further stated that appropriate interventions and implementations should be developed and implemented based on the results of a correctly completed evaluation for each resident.During a review of the facility's policy and procedures (P&P) titled, Fall Risk Assessment last reviewed on 1/28/2026, the P&P indicated, The nursing staff, in conjunction with the attending physician, consultant pharmacist, therapy staff, and others, will seek to identify and document resident risk factors for falls and establish a resident-centered falls prevention plan based on relevant assessment information. The nursing staff, attending physician, and consultant pharmacist will review for medications or (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medication combinations that could relate to falls or fall risk, such as those that have side effects of dizziness, ataxia, or hypotension. Assessment data shall be used to identify underlying medical conditions that may increase the risk of injury from falls. The staff, with the support of the attending physician, will evaluate functional and psychological factors that may increase fall risk, including ambulation, mobility, gait, balance, excessive motor activity, activities of daily living (ADL) capabilities, activity tolerance, continence, and cognition.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that the Physician Progress Notes (records documenting the physician's assessment, evaluation, and management of resident care) were maintained as required for one of three sampled residents (Resident 1).This deficient practice had the potential to result in inconsistent care coordination due to incomplete documentation and placed Resident 1 at risk for poor continuity of care and unmet care needs.During a review of Resident 1's admission Record, the admission Record indicated that the facility originally admitted Resident 1 on 2/20/2026 and readmitted on [DATE] with diagnoses that included diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing), hemiplegia (total paralysis [loss of ability to move part or all of the body] of the arm, leg, and trunk on the same side of the body) and hemiparesis (paralysis or weakness on one side of the body) following cerebral infarction (known as stroke, loss of blood flow to a part of the brain resulting in damage to brain tissue), chronic kidney disease (a long-term condition where the kidneys are damaged and cannot effectively filter waste and extra fluid from the blood), and psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality).During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 2/24/2026, the MDS indicated that Resident 1's cognition (ability to think, reason, and function) was intact. The MDS indicated that Resident 1 required moderate assistance from staff with oral care, toileting, personal hygiene, showering, lower body dressing, bed mobility (movement), and transfers for chair/bed-to-chair and toilet. The MDS further indicated that Resident 1 was independent with eating.During a review of Resident 1's Situation-Background-Assessment-Recommendation (SBAR - a communication tool used by healthcare workers when there is a change of condition among the residents) Communication form dated 3/16/2026, timed at 6:50 p.m., the SBAR indicated that Resident 1 verbalized statements expressing a belief Resident 1 was going to die and reported feelings of hopelessness, as reported by Resident 1's family.During a review of Resident 1's Physician's Order dated 3/16/2026, timed at 7 p.m., the Physician's Order indicated an order for a psychiatry (the branch of medicine focused on diagnosing, treating, and preventing mental, emotional, and behavioral disorders) evaluation to be conducted by a psychiatrist (a medical doctor specializing in mental health).During a concurrent interview and record review on 4/9/2026 at 4:22 p.m., with Registered Nurse 2 (RN 2), no Physician Progress Notes were found in Resident 1's clinical record related to Resident 1's psychiatry evaluation since 3/16/2026. RN 2 stated that the psychiatry consultation note could not be located. RN 2 stated that follow-up for Resident 1's mood changes, including statements of wanting to die and feelings of hopelessness, should have occurred on the same day or, at minimum, the following day.During an interview on 4/10/2026 at 1:15 p.m., with the Director of Nursing (DON), the DON stated that the facility received Resident 1's Psychiatry Progress Notes dated 3/16/2026 from Psychiatrist 1 during a quality assurance meeting held on 3/25/2026. During a follow-up interview on 4/10/2026 at 4:03 p.m., with the DON, the DON stated that Psychiatrist 1 provided Resident 1's Psychiatry Progress Notes dated 3/16/2026 in person several weeks after examining the resident. The DON stated that the facility needed to address this issue with the physicians, as some do not consistently provide their documentation on the same day services are rendered. When the DON was asked about the importance of maintaining physician progress notes in the resident's clinical record, the DON stated that such documentation reflects the resident's care needs and the services provided to the residents. The DON further stated that physician notes should be received within seven (7) days of the date of service.During a review of the facility's policy and procedures (P&P) titled, Physician Services last reviewed on 1/28/2026, the P&P indicated, Physician orders and progress notes are maintained in accordance with current OBRA (stands for Omnibus Budget Reconciliation Act, also (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	known as the Nursing Home Reform Act of 1987, setting federal standards of how care should be provided to residents) regulations and facility policy.During a review of the facility's P&P titled, Physician Progress Notes last reviewed on 1/28/2026, the P&P indicated, Physician progress notes must be maintained for each resident. Physician progress notes reflect the resident's progress and response to his or her care plan, medications, etc.

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	04/10/2026

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility's licensed nurses failed to follow physician orders for one of three sampled residents (Resident 1) to check blood sugar (BS) two times a day for diabetes mellitus (DM - a disorder characterized by difficulty in BS control and poor wound healing) before breakfast and before dinner, and to notify the physician when BS levels exceed 200 milligrams per deciliter (mg/dl - unit of measurement). These deficient practices had the potential to result in medication errors and negatively affect the delivery of care and services to Resident 1.During a review of Resident 1's admission Record, the admission Record indicated that the facility originally admitted Resident 1 on 2/20/2026 and readmitted on [DATE] with diagnoses that included diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing), hemiplegia (total paralysis [loss of ability to move part or all of the body] of the arm, leg, and trunk on the same side of the body) and hemiparesis (paralysis or weakness on one side of the body) following cerebral infarction (known as stroke, loss of blood flow to a part of the brain resulting in damage to brain tissue), chronic kidney disease (a long-term condition where the kidneys are damaged and cannot effectively filter waste and extra fluid from the blood), and psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality).During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 2/24/2026, the MDS indicated that Resident 1's cognition (ability to think, reason, and function) was intact. The MDS indicated that Resident 1 required moderate assistance from staff with oral care, toileting, personal hygiene, showering, lower body dressing, bed mobility (movement), and transfers for chair/bed-to-chair and toilet. The MDS further indicated that Resident 1 was independent with eating.During a review of Resident 1's Order Summary Report, the Order Summary Report indicated that there was a Physician Order dated 2/20/2026 to check BS two times a day for DM before breakfast and before dinner, and to notify the physician when BS levels were greater than 200 (mg/dl). During a review of Resident 1's Medication Administration Record (MAR - a report detailing the medications administered to a resident by a healthcare professional at a facility) for 3/2026, the MAR indicated that licensed nurses documented BS checks at 9 a.m. and 6 p.m. The MAR further indicated multiple instances in which Resident 1's BS levels exceeded 200 mg/dl, as follows: On 3/1/2026 at 9 a.m. BS was 256, and at 6 p.m. BS was 298. On 3/2/2026 at 6 p.m. BS was 366. On 3/3/2026 at 9 a.m. BS was 254, and at 6 p.m. BS was 314. On 3/4/2026 at 9 a.m. BS was 278, and at 6 p.m. BS was 307. On 3/5/2026 at 9 a.m. BS was 253, and at 6 p.m. BS was 356. On 3/6/2026 at 9 a.m. BS was 241, and at 6 p.m. BS was 388. On 3/7/2026 at 9 a.m. BS was 370, and at 6 p.m. BS was 361. On 3/8/2026 at 9 a.m. BS was 247. On 3/9/2026 at 6 p.m. BS was 350. On 3/10/2026 at 6 p.m. BS was 457. On 3/11/2026 at 9 a.m. BS was 243, and at 6 p.m. BS was 440. On 3/12/2026 at 6 p.m. BS was 419. On 3/13/2026 at 6 p.m. BS was 352. On 3/14/2026 at 9 a.m. BS was 368, and at 6 p.m. BS was 350. On 3/15/2026 at 9 a.m. BS was 382, and at 6 p.m. BS was 260. On 3/16/2026 at 6 p.m. BS was 211. On 3/17/2026 at 9 a.m. BS was 234, and at 6 p.m. BS was 418. On 3/18/2026 at 6 p.m. BS was 313. On 3/20/2026 at 6 p.m. BS was 258. On 3/21/2026 at 9 a.m. BS was 224. On 3/23/2026 at 6 p.m. BS was 291. On 3/25/2026 at 6 p.m. BS was 232. On 3/26/2026 at 9 a.m. BS was 241, and at 6 p.m. BS was not checked due to hospitalization.During a concurrent interview and record review on 4/10/2026 at 1:07 p.m., with Registered Nurse 1 (RN 1), Resident 1's Physician Order dated 2/20/2026 and MAR for 3/2026 were reviewed. RN 1 stated that RN 1 documented Resident 1's BS as 457 on 3/10/2026 at 6 p.m., 440 on 3/11/2026 at 6 p.m., and 419 on 3/12/2026 at 6 p.m. RN 1 further stated that Resident 1's BS was checked after meals rather than before meals, as ordered. RN 1 further stated that the physician was not notified regarding the elevated BS levels exceeding 200 mg/dl. During a concurrent interview and record review on 4/10/2026 at 1:20 p.m., with RN 1 and Licensed Vocational Nurse 1 (LVN 1), Resident 1's Physician Order dated 2/20/2026 and MAR for (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3/2026 were reviewed. LVN 1 stated that LVN 1 was the charge nurse for the morning shift for Resident 1 and overlooked the prescribed BS checking times. LVN 1 stated that the physician's order was to check BS before meals, however, the MAR was incorrectly transcribed to indicate 9 a.m. and 6 p.m. after meals, and LVN 1 followed the incorrect times. When LVN 1 was asked whether the physician was notified regarding BS levels greater than 200 mg/dl per the physician order, LVN 1 stated that the physician was probably called once or twice but LVN 1 could not recall the specific dates or times. RN 1 reviewed Resident 1's Progress Notes from 3/1/2026 to 3/26/2026 and stated that there was no documentation found indicating that licensed nurses notified the physician regarding Resident 1's elevated BS levels greater than 200 mg/dl. During a concurrent interview and record review on 4/10/2026 at 3:18 p.m., with Registered Nurse 3 (RN 3), Resident 1's Physician Order dated 2/20/2026 and MAR for 3/2026 were reviewed. RN 3 reviewed all BS values documented by RN 3 at 6 p.m. on the following dates: 3/2/2026, 3/3/2026, 3/5/2026, 3/6/2026, 3/9/2026, 3/13/2026, 3/16/2026, 3/17/2026, 3/18/2026, 3/20/2026, 3/23/2026, and 3/25/2026. RN 3 stated that the Physician's Order to check BS before meals and to notify the physician for BS levels greater than 200 mg/dl was missed. RN 3 stated that Resident 1's BS was checked after meals instead of before meals and that the physician was not notified consistently for elevated BS readings. RN 3 further stated that the physician may have been contacted a couple of times regarding elevated BS levels, however, were not documented. RN 3 further stated that licensed nurses should notify the physician of elevated BS levels, as such elevations may be related to insulin (a hormone that helps regulate blood sugar levels) and may require adjustments to the plan of care, including changes to anti-hyperglycemic medications (used to treat DM by lowering high blood sugar levels) to control BS level. During a concurrent interview and record review on 4/10/2026 at 4:23 p.m., with the Director of Nursing (DON), Resident 1's Physician Order dated 2/20/2026, MAR for 3/2026 and BS summaries since the original admission on [DATE] were reviewed. The DON stated that the licensed nurses should notify the physician of elevated BS greater than 200 mg/dl, regardless of whether the BS readings were obtained before or after meals. The DON further stated that it is the responsibility of the licensed nurses to report elevated BS levels along with the resident's current anti-hyperglycemic medications so the physician can determine whether changes to the plans of care are necessary to achieve better BS control. The DON stated that licensed nurses should monitor and document symptoms associated with high blood sugar such as excessive thirst, frequent urination, fatigue, blurry vision, and headaches. During a review of the facility's policy and procedures (P&P) titled, Diabetes - Clinical Protocol last reviewed on 1/28/2026, the P&P indicated, The physician will order desired parameters for monitoring and reporting information related to blood sugar management. The staff will incorporate such parameters into Medication Administration Record and care plan.During a review of the facility's P&P titled, Administering Medications last reviewed on 1/28/2026, the P&P indicated, If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication will contact the prescriber, the resident's attending physician or the facility's medical director to discuss the concerns.