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	03/13/2025

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38549 Based on interview and record review, the facility failed to: 1. Ensure a copy of the resident's Advance Directive (a legal document indicating resident preference on end-of-life treatment decisions) was readily available in the resident's medical record for one (Resident 49) out of six sampled residents investigated for Advance Directives. 2. Ensure two of six sampled residents (Resident 20 and Resident 291) were provided written information concerning the right to refuse or accept medical or surgical treatments and formulate an Advanced Directive upon admission. These deficient practices had the potential to create confusion, which could lead to conflict with the resident's wishes regarding his/her health care. Findings: 1. During a review of Resident 49's Admission Record, the Admission Record indicated the facility admitted the resident on 1/31/2025 with diagnoses including metabolic encephalopathy (a brain dysfunction resulting from a chemical imbalance in the blood, often caused by underlying systemic illnesses or organ dysfunction, rather than a primary brain injury). During a review of Resident 49's Minimum Data Set (MDS - a resident assessment tool), dated 2/4/2025, the MDS indicated the resident had moderately impaired cognition (thought processes) and required moderate assistance from staff for most activities of daily living (ADLs - activities such as bathing, dressing, and toileting a person performs daily). During a concurrent interview and record review on 3/11/2025 at 1:36 p.m., with Registered Nurse 1 (RN 1), reviewed Resident 49's Advance Directive Acknowledgement form, dated 1/31/2025. RN 1 confirmed that the Advance Directive Acknowledgement form indicated that the resident had an Advance Directive. RN 1 stated he could not find a copy of the resident's Advance Directive in the resident's medical record. During an interview on 3/11/2025 at 1:44 p.m., with Resident 49, in the presence of RN 1, Resident 49 confirmed she did have an Advance Directive. (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: 555578	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2025
NAME OF PROVIDER OR SUPPLIER Holiday Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 3/11/2025 at 1:47 p.m., with the Social Services Designee (SSD), reviewed Resident 49's Social Services progress notes. The SSD stated she did not have any documentation indicating that she followed up with either the resident or the resident's family regarding obtaining a copy of the Advance Directive. During an interview on 3/12/2025 at 10:54 a.m., the SSD stated that the purpose of an Advance Directive was so that the resident can communicate their needs and wishes regarding their healthcare. The SSD stated it was important to have a copy of the resident's Advance Directive readily available in the medical record so that the facility was aware of and could carry out the resident's healthcare wishes. The SSD stated if they did not have a copy of the resident's Advance Directive, and an emergency came up, there was a potential that the facility will not know how to carry out the resident's wishes for their healthcare and may potentially do something that goes against their wishes. The SSD stated she should have followed up with the resident or the resident's family member immediately to obtain a copy of the resident's Advance Directive. During a review of the facility's policy and procedure titled, Advance Directives, last reviewed on 2/26/2025, the policy and procedure indicated that Advance Directives are honored in accordance with state law and facility policy. Prior to or upon admission of a resident, the social service director or designee inquires of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives. If the resident or the residents representative has executed one or more advance directive(s), or executes one upon admission, copies of these documents are obtained and maintained in the same section of the residents medical record and are readily retrievable by any facility staff. The residents wishes are communicated to the resident's direct care staff and physician by placing the advance directive documents in a prominent, accessible location in the medical record and discussing the resident's wishes in care planning meetings. 44309 2.a. During a review of Resident 20's Admission Record (face sheet), the Admission Record indicated that the facility originally admitted the resident on 2/3/2025, and readmitted on [DATE], with diagnoses including sepsis (a life-threatening blood infection), type two (2) diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and encounter for attention to gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). During a review of Resident 20's Minimum Data Set (MDS-a resident assessment tool) dated 3/1/2025, the MDS indicated that the resident`s cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated that Resident 20 was dependent to staff (helper does all the effort) for oral hygiene, toileting hygiene, personal hygiene, showering, and bathing, and upper and lower body dressing. During a review of Resident 20's Advance Directive Acknowledgement Form (ADA-a document provided by the facility that indicates whether a resident has an AD, would like information regarding creation of an AD, or refusal to create an AD), the form in the resident`s chart was blank with no entries on it. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 3/11/2025 at 11:25 a.m., with Registered Nurse 2 (RN2), Resident 20's ADA form was reviewed. RN 2 stated that Resident 20 was readmitted to the facility on [DATE] and he has a conservator (a person appointed by the court to make decisions about personal matters for the resident, including decisions about medical care, food, clothing, where the person will live). However, the resident`s ADA form was not completed. RN 2 stated there is no evidence that Resident 20 or his responsible party was provided with written information concerning the right to refuse or formulate an advance directive. During a concurrent interview and record review on 3/11/2025 at 11:36 a.m., with the facility`s Medical Record Director (MRD), Resident 20`s ADA form was reviewed. The MRD stated that Resident 20`s ADA form was not completed upon his admission to the facility, and it is blank. The MRD stated that the ADA form is required to be completed upon resident`s admission to the facility. MRD stated that the ADA form contains information regarding the resident`s right to be informed and to receive information on how to formulate an AD. MRD stated that the potential outcome of not completing ADA form is that the resident`s wishes may not be honored. During review of the facility's Policy and Procedure (P&P) titled, Advance Directives, last reviewed on 2/26/2025, the P&P indicated that the resident has the right to formulate an AD, including the right to accept or refuse medical or surgical treatment. Advanced directives are honored in accordance with state law and facility policy. Prior to or upon admission of a resident the social services director or designee inquires of the resident, his/her family members and/or his or her legal representative, about the existence of any written advanced directives. The resident pr representative is provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an AD if he or she chooses to do so. If the resident is incapacitated and unable to receive information about his or her right to formulate an AD, the information may be provided to the resident`s legal representative. Nursing staff will document in the medical record the offer to assist and the resident`s decision to accept or decline assistance. 47883 2.b. During a review of Resident 291's Admission Record, the Admission Record indicated that the resident was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy (a problem in the brain caused by a chemical imbalance in the blood), acute respiratory failure (a condition in which your blood doesn't have enough oxygen causing shortness of breath and difficulty breathing, often caused by a disease or injury), and chronic kidney disease (a condition in which the kidneys are damaged and cannot filter blood well). During a review of Resident 291's History and Physical (H&P- a comprehensive assessment of a patient's health, performed by a doctor during an initial visit), dated 1/25/2014, the H&P indicated that Resident 291 had the capacity to understand and make decisions. During a review of Resident 291's Scheduled Minimum Data Set (MDS - a standardized assessment and screening tool), dated 12/23/2025, indicated that Resident 291 had severely impaired cognition (severely damaged mental abilities, including remembering things, making decisions, concentrating, or learning). The MDS also indicated that the resident needed supervision with eating, moderate assistance with oral and personal hygiene and was dependent on 2 or more helpers with bed mobility, shower transfer, dressing, and toileting. (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 3/11/2025 at 11:48 A.M. with the Social Services Director (SSD) reviewed Resident 291's physical chart. The SSD stated that the advance directive acknowledgement form was completely blank, and she does not have any evidence that the resident was provided with written information concerning the right to refuse or formulate an advance directive if he chooses to do so. The SSD also stated that the advance directive acknowledgement form should have been signed by Resident 291 on admission. During an interview on 3/13/2025 at 3:47 P.M., with the Director of Nursing (DON), the DON stated that it is important to have the advance directive acknowledgement form in Resident 291's clinical record because it contains information about the resident's right to accept or refuse medical treatment and the right to formulate an advanced directive. The DON stated that the facility should provide written information regarding Advanced Directives to the resident or the resident's representative at the time of admission. During a review of the facility's policies and procedures titled Advance Directives, revised 2/26/2025, the policy indicated: Prior to or upon admission of a resident, the social services director or designee inquires of the resident , his/her family member and or his or her legal representative , about the existence of any written advance directive. The resident or representative is provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so.

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38549 Based on interview and record review, the facility failed to: 1. Protect a resident's right to be free from verbal abuse (a type of abuse that uses language) for one of out of five sampled residents (Resident 50), when on 3/12/2025 Resident 15 yelled at Resident 50, Shut up, you fucking bitch. This deficient practice resulted in Resident 50 being subjected to verbal abuse while under the care of the facility. Residents who are subjected to verbal abuse are at increased risk for low self-esteem (when someone lacks confidence in themselves and their abilities), anxiety (a feeling of fear, dread, and uneasiness), depression (mood disorder that causes a persistent feeling of sadness and loss of interest in activities for long periods of time) and social isolation (when someone has few or no social connections or support and lacks relationships with others). 2. Protect the resident`s right to be free from physical abuse (deliberately aggressive or violent behavior with the intention to cause harm by one resident towards another) for one of five sampled residents (Resident 61), when on 3/3/2025, Resident 18 pushed Resident 61 causing Resident 61 to fall. As a result, Resident 61 was subjected to physical abuse by Resident 18 while under the care of the facility. Findings: 1. During a review of Resident 50's Admission Record, the Admission Record indicated the facility originally admitted the resident on 1/9/2020 and readmitted the resident on 12/16/2024 with diagnoses including major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 50's Minimum Data Set (MDS - a resident assessment tool), dated 1/7/2025, the MDS indicated the resident had intact cognition (thought processes) and was dependent on staff for most activities of daily living (ADLs - activities such as bathing, dressing, and toileting a person performs daily). During a review of Resident 50's Situation, Background, Assessment, and Recommendation Communication Form (SBAR - a communication tool used by healthcare workers when there is a change of condition among the residents), dated 3/12/2025, the SBAR indicated that the resident was interacting with another resident. The SBAR indicated that Resident 50 stated, He [Resident 15] was fixing the wall. I told him to stop. Then he called me a bitch. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 15's Admission Record, the Admission Record indicated the facility originally admitted the resident on 1/24/2025 and readmitted the resident on 2/20/2025 with diagnoses including metabolic encephalopathy (a brain dysfunction resulting from a chemical imbalance in the blood, often caused by underlying systemic illnesses or organ dysfunction, rather than a primary brain injury), history of traumatic brain injury (TBI - a disruption in the normal function of the brain that can be caused by a bump, blow, or jolt to the head), dementia (a progressive state of decline in mental abilities), schizophrenia (a mental illness that is characterized by disturbances in thought), 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 15's MDS, dated [DATE], the MDS indicated the resident had severely impaired cognition and required maximal assistance from staff for most ADLs. On 3/12/2025 at 2:01 p.m., during an interview with Registered Nurse 2 (RN 2), RN 2 stated she was sitting at north nursing station when she heard a commotion. RN 2 stated she heard Resident 50 yelling but could not understand what Resident 50 was saying. RN 2 stated that, when she asked Resident 50 what happened, Resident 50 pointed at Resident 15 and stated that she was trying to tell Resident 15 to stop moving the personal protective equipment (PPE - clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) bin that was outside of his room. RN 2 stated that Resident 50 told her that Resident 15 then responded by saying, Shut up, bitch! On 3/12/2025 at 3:54 p.m., during an interview with the Director of Staff Development (DSD), the DSD stated that, between 7:15 a.m. and 7:30 a.m., he heard Resident 50 yelling, Stop cleaning the walls, and stop moving the signs! The DSD stated he observed Resident 15 outside his room removing signs that were outside his room. The DSD stated he then heard Resident 15 shout, Shut up! to Resident 50. On 3/13/2025 at 8:38 a.m., during an interview with Resident 50, Resident 50 stated she saw Resident 15 taking off the sign in front of his door, so she yelled for him to stop. Resident 50 stated that Resident 15 responded by yelling, Fuck you, bitch! Shut up, bitch! On 3/13/2025 at 9:09 a.m., during an interview with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated that, between 7 a.m. to 7:15 a.m., she heard Resident 50 speaking very loudly. CNA 1 stated that, when she got to Resident 50's room, she observed Resident 50 yelling profanities at Resident 15, and she tried to tell Resident 50 to stop. CNA 1 stated that Resident 15 responded to Resident 50 by stating, Shut up, you fucking bitch. On 3/13/2025 at 11:37 a.m., during an interview with the Administrator (ADM), the ADM stated that, at around 7:55 a.m., RN 2 notified her of the verbal resident-to-resident incident between Resident 50 and Resident 15. The ADM stated RN 2 told the ADM that Resident 50 was trying to tell Resident 15 to stop moving around the signs outside of his room. The ADM stated she was told that Resident 15 responded to Resident 50 by stating, Shut up, you fucking bitch. On 3/13/2025 at 4:20 p.m., during an interview with the ADM, when asked if she (ADM) considered Resident 15 stating Shut up, you fucking bitch, to Resident 50 to be verbal abuse, the ADM stated that she did consider the incident as verbal abuse. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure titled, Abuse Prevention/Prohibition, last reviewed on 2/26/2025, the policy and procedure indicated that the facility does not condone any form of resident abuse, neglect, misappropriation of resident property, exploitation and/or mistreatment .Verbal abuse is defined as any use of oral, written or gestured language that willfully includes disparaging and derogatory terms directed to residents or their families or within their hearing distance, to describe residents, regardless of their age, ability to comprehend, or disability. 44309 2. During a review of Resident 61's Admission Record (face sheet), the admission record indicated that the facility originally admitted the resident on 5/13/2022, and readmitted on [DATE], with diagnoses including Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), dementia (a progressive state of decline in mental abilities), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 61's Minimum Data Set (MDS - a resident assessment tool) dated 1/31/2025, the MDS indicated that the resident`s cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was moderately impaired (decisions poor, cues/supervision required). The MDS indicated that Resident 61 required staff partial/moderate assistance (helper does less than half the effort) for toileting hygiene, upper and lower body dressing, putting on/taking off footwear, and personal hygiene. During a review of Resident 61`s Situation, Background, Assessment, Recommendation Communication Form (SBAR-a communication tool used by healthcare workers when there is a change of condition among the residents) dated 3/3/2025, the SBAR communication form indicated that on 3/3/2025, Resident 61 was allegedly pushed by Resident 18 in the hallway. The SBAR form indicated that this incident was witnessed by Resident 53. During a review of Resident 61`s care plan (a document outlining a detailed approach to care customized to an individual resident's need) for risk for injury related to alleged resident to resident altercation initiated on 3/3/2025, the care plan indicated a goal that the resident will have no injuries. The care plan interventions were to monitor the resident for pain and discomfort, provide safety reassurance, redirect the resident to another area away from the group of residents, and approach the resident in a calm manner. During a review of Resident 61`s Interdisciplinary Team (IDT- a group of professionals from different disciplines who collaborate to provide comprehensive care for a patient) Conference Record-Fall Management Follow up dated 3/4/2025, the IDT follow up record indicated that Resident 61 had a fall incident on 3/3/2025, because the resident was allegedly pushed by another resident for no apparent reason and was found on the floor. The IDT follow up record indicated that Resident 61 did not sustain any injuries and X-Ray results (images of internal tissues, bones, and organs on film or digital media) were negative for any fracture. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 18's Admission Record (face sheet), the admission record indicated that the facility admitted the resident on 2/12/2025, with diagnoses including type two (2) diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), paranoid (a pattern of behavior where a person feels distrustful and suspicious of other people and acts accordingly) schizophrenia (a mental illness that is characterized by disturbances in thought), and encephalopathy (a general condition characterized by impaired brain function). During a review of Resident 18`s History and Physical (H&P) dated 2/13/2025, the H&P indicated that the resident had the capacity to understand and make decisions.  During a review of Resident 18's Minimum Data Set (MDS - a resident assessment tool) dated 2/19/2025, the MDS indicated that the resident`s cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was moderately impaired (decisions poor, cues/supervision required). The MDS indicated that Resident 18 required staff partial/moderate assistance (helper does less than half the effort) for oral hygiene, toileting hygiene, lower body dressing, showering and bathing, putting on/talking off footwear, and personal hygiene. The MDS further indicated that Resident 18 exhibited behavioral symptoms not directed towards others. During a review of Resident 61`s SBAR Communication Form dated 2/17/2025, the SBAR communication form indicated that on 2/17/2025, Resident 18 had behavioral symptoms such as throwing things and banging doors.  During a review of Resident 61`s SBAR Communication Form dated 3/3/2025, the SBAR communication form indicated that on 3/3/2025 at around 10:05 a.m., Resident 18 allegedly pushed another resident (Resident 61) without any provocation (an action or statement that is intended to make someone angry) that was witnessed by another resident (Resident 53). The SBAR form indicated that Resident 18 was immediately redirected back to his room and was placed on one-on-one supervision. The SBAR form indicated that when staff asked Resident 18 why he pushed Resident 61, Resident 18 stated that Resident 61 was making him uncomfortable and nervous. However, he (Resident 18) did not mean to hurt Resident 61, and he apologized. The SBAR form further indicated that Resident 18`s physician ordered to transfer the resident to hospital for psychological evaluation.  During a review of Resident 18`s care plan for alleged physical altercation with another resident, initiated on 3/3/2025, the care plan indicated that Resident 18 was the aggressor (the person who starts the attach first). The care plan indicated a goal that the resident`s behavior will be managed without complications and the resident will have minimized altercations with other residents. The care plan interventions were to provide one on one supervision, administer medications as ordered by the physician, assess for signs and symptoms that may trigger behaviors, redirect the resident to another area away from the group of residents, and approach the resident in a calm manner. During a review of Resident 53's Admission Record (face sheet), the admission record indicated that the facility admitted the resident on 7/31/2024, with diagnoses including paranoid schizophrenia, and anxiety disorder (a condition in which a person has excessive worry and feelings of fear). (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 53's MDS dated [DATE], the MDS indicated that the resident`s cognitive skills for daily decision making was moderately impaired. The MDS indicated that Resident 53 was independent (resident completes the activity by herself) for eating, oral hygiene, toileting hygiene, upper and lower body dressing, putting on/taking off footwear, and personal hygiene. During an observation on 3/10/2025 at 9:50 a.m., Resident 61 was observed walking in the hallways. Resident 61 appeared confused and was not able to answer any questions. During an interview on 3/10/2025 at 9:00 a.m., with Certified Nursing Assistant 2 (CNA 2), CNA 2 stated that on 3/3/2025 at around 10:00 a.m., she was assisting a resident inside a room when she heard a noise and commotion (a sudden, noisy, and confused activity or excitement). CNA 2 stated when she came out, she (CNA 2) Observed Resident 61 sitting on the floor in the hallway and the nurses were taking care of her. CNA 2 stated Resident 61 is confused and likes to walk in the hallways back and forth all the time. During an Interview on 3/12/2025 at 9:30 a.m., with Licensed Vocational Nurse 3 (LVN 3), LVN 3 stated on 3/3/2025, he was inside a resident`s room when he (LVN 3) heard commotion outside in the hallway. LVN 3 stated he (LVN 3) ran outside, and observed Resident 18 standing in the hallway and Resident 61 was sitting on the floor next to him. LVN 3 stated Resident 53 was present in the hallway as well and stated she (Resident 53) witnessed Resident 18 pushed Resident 61 causing her to fall. The LVN 3 stated when he (LVN 3) interviewed Resident 18 about the reason he (Resident 18) pushed Resident 61, Resident 18 stated that Resident 61 was making him uncomfortable and nervous, and he (Resident 18) did not mean to hurt Resident 61. During an interview on 3/12/2025 at 10:14 a.m., Resident 53 stated that she remembers the day Resident 18 pushed Resident 61. Resident 53 stated that Resident 61 is always walking in the hallway. Resident 53 stated on 3/3/3024 in the morning in the hallway next to her room, she witnessed that Resident 61 walked towards Resident 18 and told him something. Resident 53 stated that Resident 61 always starts talking to others, but nobody understands her. Resident 53 further stated that Resident 18 pushed Resident 61 causing her to fall on the floor and hit her head against the wall. Resident 53 stated she (Resident 53) got very angry, screamed Why did you do that, and then reported this incident to the nurses. During an interview on 3/13/2025 at 2:40 p.m., with the Director of Nursing (DON), the DON stated that the physical altercation between Resident 18 and Resident 61 was substantiated (to show something to be true, or to support a claim with facts) because it was witnessed by Resident 53. The DON stated Resident 53 reported that she witnessed Resident 18 pushed Resident 61 causing her to fall. The DON stated Resident 18 stated that he thought Resident 61 was following him, so he (Resident 18) pushed Resident 61. However, he (Resident 18) was sorry for his actions. During an interview on 3/13/2025 at 4:17 p.m., with the Administrator (ADM), The ADM stated that the abuse allegation was substantiated because Resident 53 witnessed that Resident 18 pushed Resident 61 causing her to fall. The ADM stated this altercation is considered physical abuse. The ADM stated it is important to protect the residents by keeping the residents safe from abuse and injury. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Holiday Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility`s Policy and Procedure (P&P) titled Abuse Prevention/prohibition, last reviewed on 2/26/2025, the P&P indicated that that facility does not condone any form of resident abuse, neglect (fail to care properly), misappropriation of resident property, mistreatment, and develops facility policies, training programs, and systems in order to promote and environment free from abuse and mistreatment. The Administrator as abuse prevention coordinator is responsible for the coordination and implementation of the facility`s abuse preventions policies and training.  During a review of the facility`s Policy and Procedure (P&P) titled Resident-to Resident Altercation, last reviewed on 2/26/2025, the P&P indicated that facility staff monitor residents for aggressive/inappropriate behaviors towards other residents, family members, visitors, or to staff. Behaviors that may provoke a reaction by residents or others include physically aggressive behaviors such as hitting, kicking, grabbing, scratching, pushing/shoving, biting, spitting, threatening gestures, and throwing objects.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44309 Based on interview, and record review, the facility failed to develop a complete and accurate baseline care plan (a document that summarizes a resident's needs, goals, and care/treatment) within 48 hours of a resident's admission to the facility for one of two sampled residents (Resident 21) by failing to complete oxygen use, pain, safety risks, and skin risk sections in the resident's baseline care plan. This deficient practice had the potential of Resident 21 to not receive appropriate care and treatments. Findings: During a review of Resident 21's Admission Record, the Admission Record indicated that the facility admitted the resident on 1/7/2025 with diagnoses including acute (rapid onset and relatively short duration) respiratory failure (a serious condition that makes it difficult to breathe on your own) with hypoxia (a condition where there is an inadequate supply of oxygen to the body's tissues), difficulty in walking, dementia (a progressive state of decline in mental abilities), and history of falling. During a review of Resident 21's Minimum Data Set (MDS - a resident assessment tool) dated 1/11/2025, the MDS indicated that the resident's cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was moderately impaired. The MDS indicated that Resident 21 required staff partial/moderate assistance (helper does less than half the effort) for oral hygiene, showering and bathing, and personal hygiene The MDS further indicated that Resident 21 received oxygen therapy on admission and within the last 14 days. During a review of Resident 21's Order Summary Report dated 1/7/2025, the Order Summary Report indicated an order to administer oxygen at two (2) liters per minute (LPM- unit of measurement for ozygen) via nasal canula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) as needed (PRN) for shortness of breath (SOB). During a concurrent interview and record review on 3/13/2025 at 11:39 a.m., with the Assistant Director of Nursing (ADON), reviewed Resident 21's baseline care plan. The ADON stated that she (ADON) developed Resident 21's baseline care plan on 1/7/2025, however, the baseline care plan is missing information in multiple sections and is incomplete. The ADON stated she did not indicate that Resident 21 was receiving PRN oxygen since he was admitted to the facility on [DATE]. The ADON stated she did not complete the following sections of Resident 21's baseline care plan: pain, safety risks, and skin risk. The ADON stated this was a mistake on her part and she should have assessed the resident thoroughly. The ADON stated that residents' baseline care plans must be completed accurately reflecting all the pertinent information regarding residents within 48 hours of their admission to the facility. The ADON stated the potential outcome of not thoroughly completing a resident's baseline care plan is the inability to meet the resident's immediate care needs and lack of care. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/13/2025 at 2:45 p.m., with the Director of Nursing (DON), the DON stated a resident's baseline care plan is required to be completed within 48 hours of resident's admission to the facility. The DON stated upon admission, licensed staff are required to develop a complete and thorough baseline care plan for each resident. The DON stated Resident 21's baseline care plan developed on 1/7/2025 was not completed thoroughly. The DON stated the potential outcome is the inability to meet the resident's immediate care needs and the delivery of necessary services to the resident. During review of the facility's policy and procedure (P&P) titled, Baseline Care Planning, last reviewed on 2/26/2025, the P&P indicated that it is the policy of the facility to develop and provide a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care that meets professional standard and quality of care. The baseline care plan must include the minimum healthcare information necessary to properly care for resident immediately upon admissions, which would address resident-specific health and safety concerns to prevent decline or injury, such as elopement or fall risk and would identify needs for supervision, behavioral interventions, and assistance with activities of daily living as needed.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38549 Based on interview and record review, the facility failed to develop a comprehensive person-centered care plan (a document that summarizes a resident's needs, goals, and care/treatment) by failing to: 1. Develop a care plan addressing a resident's diagnosis of post-traumatic stress disorder (PTSD - a disorder in which a person has difficulty recovering after experiencing or witnessing a traumatic event) for one of one sampled resident (Resident 49) investigated for trauma-informed care. 2. Develop a care plan addressing a resident's restorative nursing assistant (RNA - an ongoing program that focuses on helping individuals, especially those in long-term care, maintain and improve their functional abilities and independence, often following rehabilitation) therapy for one of two sampled residents (Resident 47) investigated under the care area of position and mobility. 3. Resident 85's refusal of vaccination for Covid-19 (disease cause by the SARS-CoV-2 virus, that spreads throiugh respiratory droplets. Most people infected with the virus will experience mild to moderate respiratory illness) and influenza (viral infection of the nose, throat and lungs). 4. Resident 63' activities preferences. 5. Resident 21's use of oxygen. These deficient practices had the potential to result in failure to deliver the necessary care and services. Findings: 1. During a review of Resident 49's Admission Record, the Admission Record indicated the facility admitted the resident on 1/31/2025 with diagnoses including PTSD. During a review of Resident 49's Minimum Data Set (MDS - a resident assessment tool) dated 2/4/2025, the MDS indicated the resident had moderately impaired cognition (thought processes) and required moderate assistance from staff for most activities of daily living (ADLs - activities such as bathing, dressing, and toileting a person performs daily). The MDS also indicated the resident has a diagnosis of PTSD. During a concurrent interview and record review on 3/11/2025 at 1:56 p.m., with Registered Nurse 1 (RN 1), reviewed Resident 49's care plans dated 1/31/2025 to 3/11/2025. RN 1 stated that Resident 49 had a diagnosis of PTSD. RN 1 stated he could not find a care plan addressing Resident 49's diagnosis of PTSD. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/12/2025 at 11:18 a.m., with the Director of Nursing (DON), the DON stated it was important for 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) to determine the specific care Resident 49 would need for her PTSD. The DON stated it was important to note what triggered Resident 49 so that facility staff could avoid those triggers. During a review of the facility's policy and procedure titled, Care Plans, Comprehensive Person-Centered, last reviewed on 2/26/2025, the policy and procedure indicated that a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. Services provided for or arranged by the facility and outlined in the comprehensive care plan are provided by qualified persons; culturally competent; and trauma-informed. During a review of the facility's policy and procedure titled, Trauma Informed Care and Culturally Competent Care, last reviewed on 2/26/2025, the policy and procedure indicated to develop individualized care plans that address past trauma in collaboration with the resident and family, as appropriate. Identify and decrease exposure to triggers that may re-traumatize the resident. 2. During a review of Resident 47's Admission Record, the Admission Record indicated the facility originally admitted the resident on 7/31/2023 and readmitted the resident on 9/10/2024 with diagnoses including difficulty in walking and muscle wasting and atrophy (the thinning or loss of muscle tissue, leading to a decrease in muscle mass and strength). During a review of Resident 47's MDS dated [DATE], the MDS indicated the resident had severely impaired cognitive skills for daily decision making and required maximal assistance from staff for most ADLs. During a concurrent interview and record review on 3/12/2025 at 9:54 a.m., with RN 1, reviewed Resident 47's physician's orders and Resident 47's care plans dated 9/10/2024 to 3/12/2025. RN 1 stated Resident 47 had a physician's order for RNA passive range of motion (PROM - moving a joint through its full range of motion without the resident's active muscle contraction) exercises on the bilateral upper extremities (BUE) every day five times a week or as tolerated, ordered on 12/18/2024. RN 1 stated Resident 47 also had a physician's order for RNA for ambulation (walking) with a front wheel walker (FWW) as tolerated every day for five times a week with two-person assistance for safety, ordered on 12/18/2024. RN 1 stated he could not find any care plans addressing Resident 47's RNA treatments. During an interview on 3/12/2025 at 11:21 a.m., with the DON, the DON stated that Resident 47 should have had a care plan addressing his RNA treatments. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure titled, Care Plans, Comprehensive Person-Centered, last reviewed on 2/26/2025, the policy and procedure indicated that a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. The comprehensive, person-centered care plan includes measurable objectives and timeframes; describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; includes the resident's stated goals upon admission and desired outcomes; builds on the resident's strengths; and reflects currently recognized standards of practice for problem areas and conditions. 47883 3. During a review of Resident 85's Admission Record, the Admission Record indicated the facility admitted the resident on 12/11/2024 and readmitted her on 1/17/2025 with diagnoses including chronic obstructive pulmonary disease (COPD- long -term disease that makes it hard to breath), essential hypertension (high blood pressure), and major depression (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). During a review of Resident 85's History and Physical (H&P - a comprehensive assessment that involves a healthcare provider obtaining a thorough medical history from the patient and performing a physical examination to understand their current health status and any presenting problems), dated 12/12/2024, the H&P indicated that the resident has the capacity to understand and make decisions. During a review of Resident 85's Minimum Data Set (MDS, an assessment and care screening tool) dated 3/8/2025, the MDS indicated that the resident had an intact cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) with skills required for daily decision making. The MDS indicated that Resident 85 required supervision (helper sets up or cleans up; resident completes activity) with eating and moderate assistance with oral hygiene, upper body dressing and toileting hygiene, shower and lower body dressing. During a review of Resident 85's Vaccine consent dated 12/28/2024, it indicated that Resident 85 refused Covid 19 and Influenza (viral infection of the nose, throat and lungs) vaccination. During a concurrent interview and record review on 3/12/2025 at 10:58 p.m., the Infection Preventionist (IP) reviewed Resident 85 care plans and stated that there was no care plan created addressing Resident 85 refusal of Covid 19 and Influenza vaccination. The IP stated it was important to create care plan to address and monitor Resident 85 for possible complications secondary to vaccination refusal. During an interview on 3/13/2025 at 3:47 p.m., the Director of Nursing (DON) stated that Resident 85 should had a care plan addressing his refusal of vaccination. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure titled, Care Plans, Comprehensive Person-Centered, last reviewed on 2/26/2025, the policy and procedure indicated that a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. The comprehensive, person-centered care plan includes measurable objectives and timeframes; describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; includes the resident's stated goals upon admission and desired outcomes; builds on the resident's strengths; and reflects currently recognized standards of practice for problem areas and conditions. 4.During a review of Resident 63's Admission Record, the Admission Record indicated the facility admitted the resident on 1/3/2025 with diagnoses including schizophrenia (a disorder that affects a person's ability to think, feel and behave clearly) and cellulitis (a bacterial skin infection) of left lower limb. During a review of Resident 63's History and Physical (H&P - a comprehensive assessment that involves a healthcare provider obtaining a thorough medical history from the patient and performing a physical examination to understand their current health status and any presenting problems), dated 1/31/2025, the H&P indicated that the resident has the capacity to understand and make decisions. During a review of Resident 63's Minimum Data Set (MDS, an assessment and care screening tool) dated 2/7/2025, the MDS indicated that the resident was mildly impaired in cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) with skills required for daily decision making. The MDS indicated that Resident 63 required supervision (helper sets up or cleans up; resident completes activity) with shower and personal hygiene. During a concurrent observation and interview on 3/10/2025 at 10:00 a.m., with Restorative Nursing Assistant 1 (RNA 1), Resident 63 was observed in wheelchair in the dining room, where the television (TV) was turned off. Resident 63 stated that he would like to watch television, and he does not like that the television was turned off at that time. RNA 1 stated that the activity department was playing movies at designated times throughout the of the day while at other times the residents were encouraged residents to be involve in other activities. During a concurrent interview and record review on 3/12/2025 at 10:58 p.m., the Activity Director (AD) reviewed Resident 63's activities initial review dated 02/01/2025 and care plans. The AD stated that according to past activities interests the resident liked to participate in watching TV. The AD stated that there was no care plan created to address Resident 63 activity preferences. The AD stated it was important to create care plan to address and monitor Resident 63 for his activity's preferences. During an interview on 3/13/2025 at 3:47 p.m., the Director of Nursing (DON) stated that Resident 63 should had a care plan addressing his activities preferences and needs. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure titled, Care Plans, Comprehensive Person-Centered, last reviewed on 2/26/2025, the policy and procedure indicated that a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. The comprehensive, person-centered care plan includes measurable objectives and timeframes; describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; includes the resident's stated goals upon admission and desired outcomes; builds on the resident's strengths; and reflects currently recognized standards of practice for problem areas and conditions. 44309 5. During a review of Resident 21's Admission Record (face sheet), the admission record indicated that the facility admitted the resident on 1/7/2025, with diagnoses including acute (rapid onset and relatively short duration) respiratory failure (a serious condition that makes it difficult to breathe on your own) with hypoxia (a condition where there is an inadequate supply of oxygen to the body's tissues), difficulty in walking, dementia (a progressive state of decline in mental abilities), and history of falling. During a review of Resident 21's Minimum Data Set (MDS - a resident assessment tool) dated 1/11/2025, the MDS indicated that the resident`s cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was moderately impaired (decisions poor, cues/supervision required). The MDS indicated that Resident 21 required staff partial/moderate assistance (helper does less than half the effort) for oral hygiene, showering and bathing, and personal hygiene. The MDS further indicated that Resident 21 received continuous oxygen therapy on admission and within the last 14 days. During a review of Resident 21`s Physician Order Summary Report dated 1/7/2025, the order summary report indicated to administer oxygen at two (2) liters per minute via nasal canula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) as needed (PRN) for Shortness of Breath (SOB). During a review of Resident 21's care plans, the care plans did not indicate an evidence of a comprehensive care plan addressing Resident 21`s oxygen use.  During a concurrent interview and record review on 3/13/2025 at 11:45 a.m., with Assistant Director of Nursing (ADON), Resident 21`s physician orders and care plans were reviewed. ADON stated that Resident 21 is using oxygen as needed. However, licensed staff did not develop a comprehensive care plan with person-centered interventions for the resident`s oxygen use. ADON stated it is required to develop a person-centered care plan with goal and interventions to monitor Resident 21`s oxygen use. ADON stated the potential outcome of not developing a care plan for a resident who uses oxygen is the lack of care and the inability to implement the specific services and monitoring that resident requires. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/13/2025 at 2:36 p.m., with the Director of Nursing (DON), the DON stated licensed staff are required to develop a person-centered care plan based on the residents` needs and identified problems. The DON stated licensed staff did not develop a care plan with goal and interventions for Resident 21`s oxygen use. The DON stated that the potential outcome is providing inadequate care to the resident. During a review of the facility's Policy and Procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, last reviewed on 2/26/2025, the P&P indicated that a comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident`s physical, psychosocial and functional needs is developed and implemented for each resident. The comprehensive person-centered care plan is developed within seven days of completion of the required MDS assessment and no more than 21 days after admission. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident`s problem areas and their causes, and relevant clinical decision making. Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents` conditions change.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 44309 Based on interview, and record review, the facility failed to update and revise a resident's care plan (a document that summarizes a resident's needs, goals, and care/treatment) after the resident's change of condition (a sudden, clinically important deviation from a resident's baseline in physical, cognitive, behavioral, or functional domains) on 2/17/2025, for one of two sampled residents (Resident 18). This deficient practice had the potential to result in Resident 18 receiving inadequate care and supervision at the facility. Findings: During a review of Resident 18's Admission Record, the Admission Record indicated that the facility admitted the resident on 2/12/2025 with diagnoses including type two (2) diabetes mellitus (DM- a chronic condition that affects the way the body processes blood glucose [sugar]), paranoid schizophrenia (type of schizophrenia [a mental illness that is characterized by disturbances in thought] accompanied by paranoia [way of thinking that involves feelings of distrust and suspicion about others without a good reason]), and encephalopathy (a general condition characterized by impaired brain function). During a review of Resident 18's History and Physical (H&P- a formal assessment by a healthcare provider that involves a resident interview, physical exam, and documentation of findings) dated 2/13/2025, the H&P indicated that the resident had the capacity to understand and make decisions. During a review of Resident 18's Minimum Data Set (MDS - a resident assessment tool) dated 2/19/2025, the MDS indicated that the resident's cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was moderately impaired. The MDS indicated that Resident 18 required staff partial/moderate assistance (helper does less than half the effort) for oral hygiene, toileting hygiene, lower body dressing, showering and bathing, putting on/talking off footwear, and personal hygiene. During a review of Resident 18's Situation, Background, Assessment, Recommendation Communication Form (SBAR- a communication tool used by healthcare workers when there is a change of condition among the residents) dated 2/17/2025, the SBAR communication form indicated that on 2/17/2025, Resident 18 had behavioral symptoms such as throwing things and banging door. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 18's care plan for mood problem related to schizophrenia initiated on 2/12/2025, the care plan indicated that the resident's behavior could change from calm to hostile behavior. The care plan indicated a goal that the resident will have a happier mood, calmer appearance, and no signs and symptoms of anxiety (intense, excessive, and persistent worry and fear about everyday situations). The care plan interventions were to administer the resident's medications as ordered by the physician, provide the resident with a program of activities that is meaningful and of interest, monitor/document and report to the physician any risks for harm to self and others, signs and symptoms of depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety, and sad mood. During a review of Resident 18's care plan for behavioral symptoms related to schizophrenia initiated on 2/12/2025, the care plan indicated a goal that the resident will stay calm. The care plan interventions were to administer the resident's medications as ordered by the physician, encourage verbalization of feelings and concerns, listen attentively when resident is verbalizing concerns, and to monitor resident's interaction with another resident to prevent offensive behavior (rude, hurtful, or disrespectful conduct that is likely to upset others). During a concurrent interview and record review on 3/12/2025 at 12:11 p.m., with Licensed Vocational Nurse 3 (LVN 3), reviewed Resident 18's SBAR form dated 2/17/2025 and care plans. LVN 3 stated that Resident 18's SBAR form dated 2/17/2025 indicated that the resident had behavioral symptoms such as throwing things and banging doors. LVN 3 stated licensed staff did not revise or update Resident 18's care plans addressing the resident's behavior and mood after this change of condition. LVN 3 stated licensed staff are required to revise a resident's care plan after a resident's change of condition to ensure the effectiveness of care plan interventions. LVN 3 stated the potential outcome of not updating/revising a resident care plan after a change of condition is the inability to provide appropriate care and monitoring to the resident. During an interview on 3/13/2024 at 2:50 p.m., with the Director of Nursing (DON), the DON stated that residents' care plans are required to be reviewed and revised after residents' change of condition. The DON stated Resident 18's care plans were not revised or updated after Resident 18's change of condition on 2/17/2025. The DON stated the potential outcome of not updating/revising a resident's care plan is the inability to provide appropriate care and services to the resident. During a review of the facility's policy and procedure (P&P) titled, Care Plans Comprehensive Person-Centered, last reviewed on 2/26/2025, the P&P indicated that care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. Assessments of resident's are ongoing and care plans are revised as information about the residents and the residents' conditions change. During a review of the facility's P&P titled, Change in a Resident's Condition or Status, last reviewed on 2/26/2025, the P&P indicated that the facility shall promptly notify the resident, his or her attending physician, and representative of changes in the resident's medical, mental condition and/or status. A significant change of condition is a decline or improvement in the resident's status that requires interdisciplinary review and/or revision to the care plan.

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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. 47883 Based on observation, interview, and record review, the facility failed to ensure the low air loss mattress (LALM - a specialty bed that alternates pressure to help heal and prevent pressure ulcers [an injury that breaks down the skin and underlying tissue when an area of skin is placed under pressure]) was set correctly for one of one sampled resident (Resident 291). This deficient practice had the potential to place Resident 291 at risk for discomfort and development of pressure ulcers/injuries. Findings: During a review of Resident 291's Admission Record, the Admission Record indicated the facility admitted the resident on 2/19/2025 with diagnoses of metabolic encephalopathy (a problem in the brain caused by a chemical imbalance in the blood), acute respiratory failure (a condition in which your blood doesn't have enough oxygen causing shortness of breath and difficulty breathing), and chronic kidney disease (a condition in which the kidneys are damaged and cannot filter blood well). During a review of Resident 291's History and Physical (H&P- a formal assessment by a healthcare provider that involves a resident interview, physical exam, and documentation of findings) dated 1/25/2014, the H&P indicated that Resident 291 had the capacity to understand and make decisions. During a review of Resident 291's Minimum Data Set (MDS - a resident assessment tool) dated 12/23/2025, the MDS indicated that Resident 291 had severely impaired cognition (thought process). The MDS also indicated that the resident needed supervision with eating, moderate assistance with oral and personal hygiene and was dependent on two or more helpers with bed mobility, shower transfer, dressing, and toileting. During a review of Resident 291's Weight and Vitals Summary, the Weight and Vitals Summary indicated that Resident 291 weighed 236 pounds (lbs.- unit of measurement) on 3/4/2025. During a review of Resident 291's Skin Observation Tool dated 2/21/2024, the Skin Observation Tool indicated Resident 291 had a pressure ulcer stage one (1) (redness of the skin that doesn't fade when pressure is applied) on sacrococcyx area (pertaining to both the sacrum [triangular bone located in the lower back] and coccyx [tailbone]). During a review of Resident 291's care plan (a document that summarizes a resident's needs, goals, and care/treatment) dated 2/19/2025, the care plan indicated that Resident 291 had potential impairment to skin integrity related to fragile skin and incontinence (losing control of your bladder or bowels, leading to involuntary leakage of urine or feces). The care plan intervention indicated to follow facility protocol for treatment of injury. (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 concurrent observation and interview on 3/10/2025 at 9:34 a.m., with Licensed Vocational Nurse 3 (LVN 3), in Resident 291's room, observed Resident 291's LALM setting was at seven (7) for 300 lbs. LVN 3 stated Resident 291 current weight is 236 lbs. and Resident 291's physician order dated 2/20/2025 indicated for the LALM mode to be set at alternating and setting based on comfort and/or resident weight for skin management. LVN 3 stated the LALM is an intervention to promote wound healing and prevent pressure injuries. During a concurrent record review and interview on 3/11/2025 at 2:28 p.m., with Treatment Nurse 1 (TN 1), TN 1 stated that Resident 291's stage one (1) pressure ulcer on the sacrococcyx area was resolved on 2/28/2025. TN 1 stated currently Resident 291 has intact skin and the LALM is used to prevent further injuries. TN 1 stated the correct setting on the LALM for 236 lbs. was five (5). During an interview on 3/12/2025 at 9:12 a.m., with the Assistant Director of Nursing (ADON), the ADON stated if the LALM is not set at the correct setting then it won't be effective to prevent further pressure injuries. During a review of the facility's policy and procedure titled, Support Surface Guidelines, dated 1/15/2025, the policy indicated, The purpose of this procedure is to provide guidelines for the assessment of appropriate pressure reducing and relieving devices for residents at risk of skin breakdown. During a review of the LALM user manual, the manual indicated, The comfort setting controls the air pressure output based on the resident's weight.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 47883 Based on interview, and record review, the facility failed to ensure one of one sampled resident (Resident 13) received treatment and services to prevent decrease in range of motion (ROM- full movement potential of a joint) by failing to follow Resident 13`s physician order for Restorative Nursing Assistant (RNA- nursing aide program that helps residents to maintain their function and joint mobility) exercise program. This deficient practice had the potential to place the resident at risk for further decline in range of motion (ROM- full movement potential of a joint) decline. Findings: During a review of Resident 13's Admission Record (face sheet), the Admission Record indicated that the facility admitted the resident on 9/19/2023 and readmitted the resident on 2/10/2025, with diagnoses including metabolic encephalopathy (a problem in the brain caused by a chemical imbalance in the blood), type 2 diabetes mellitus (a long-term medical condition in which the body does not use insulin [a hormone that lowers the level of sugar in the blood] properly), and difficulty in walking. During a review of Resident 13's Minimum Data Set (MDS - a resident assessment tool) dated 2/14/2025, the MDS indicated that the resident`s cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated that Resident 13 required maximal - to - moderate staff assistance (helper does more than half the effort) for toileting hygiene, showering/bathing, upper and lower body dressing, putting on/taking off footwear, personal hygiene and need supervision for eating. During a review of Resident 13 History and Physical (H&P-) dated 2/11/2025, the H&P indicated that Resident 13 did not have a capacity to understand and make decision. During a review of Resident 13's Physician Order dated 2/12/2025, the order indicated the following: RNA program for ambulation with front wheel walker (FWW - a mobility aid designed for individuals who need assistance with balance and stability while walking) as tolerate every day five (5) times a week with 2 persons assist for safety. During a review of Resident 13's Treatment Administration Record for 02/1/2025-02/28/2025, and 03/1/2025-03/12/2025, the record did not indicate any RNA treatment entries. During a concurrent interview and record review on 3/12/2025 at 12:02 PM, with Restorative Nursing Assistant 1 (RNA 1), RNA 1 reviewed Resident 13's restorative task flowsheet in electronic clinical record and stated that there was no order forwarded to restorative task to provide RNA program for Resident 13. RNA 1 stated she has never provided RNA exercises to Resident 13. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 2/13/2025 at 12:46 PM with the Director of Rehabilitation (DOR), Resident 13`s physician orders were reviewed. The DOR stated that Resident 13 was evaluated by the rehabilitation department and discharged to RNA program on 2/22/2025 because Resident 13 reached maximal potential with skilled services. The DOR stated the licensed staff should have followed Resident 13`s physician and provide RNA exercise program to as ambulating with 2-person assists. The DOR stated the potential outcome of not providing RNA treatment as ordered by the physician is a decline in Activities of Daily Living (ADLs- activities such as bathing, dressing and toileting a person performs daily), and muscle weakness. During a concurrent record review and interview on 3/12/2025 at 2:26 PM, the Director of Nursing reviewed Resident 13's physician orders, care plans and RNA task flowsheet. The DON stated that the Licensed Vocational Nurse who received the physician order for the RNA program for Resident 13 did not transfer the order to the RNA task flowsheet. The RNA was not able to see the order in the Electronic Health Record (EHR) until it was transferred to the task flowsheet. That is why Resident 13's RNA program was not started and the care plan for it was not created. The DON stated that it was important to create a person-centered care plan with measurable goals to monitor Resident 13's progress and prevent any potential decline in the functional ability of Resident 13. During review of the facility's Policy and Procedure (P&P) titled, Rehabilitative Nursing Mobility Care, last reviewed 2/16/2025, the P&P indicated: The facility rehabilitative nursing care program is designed to assists each resident to achieve and maintain an optimal level of self- care and independence . Through the resident care plan, the goal of rehabilitative nursing care is reinforced in the Activities Program, therapy services. During review of the facility's Policy and Procedure (P&P) titled, Care Plans, Comprehensive Person -Centered, last reviewed 2/16/2025, the P&P indicated: A comprehensive, person -centered care plan that includes measurable objectives and timetables to meet the resident's physical. Psychosocial and functional needs is developed and implemented for each resident.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 50033 Based on interview and record review, the facility failed to ensure Fall Risk Evaluations were completed accurately for one of three sampled residents (Resident 16). This deficient practice placed the resident at risk of not receiving appropriate care and services after a fall incident and had the potential to place the resident at an increased risk for falls. Findings: During a review of Resident 16's Admission Record, the Admission Record indicated the facility originally admitted the resident on 9/3/2021 and readmitted the resident on 2/1/2025 with diagnoses including metabolic encephalopathy (the loss of brain function due to a chemical imbalance in the blood), Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), and generalized muscle weakness. During a review of Resident 16's Minimum Data Set (MDS - a resident assessment tool) dated 2/5/2025, the MDS indicated the resident was able to make herself understood and usually understands others. The MDS further indicated Resident 16 is dependent on staff to complete most activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 16's Situation, Background, Assessment, Recommendation (SBAR- a form filled out by licensed nursing staff for the purpose of communicating information about a resident's condition or other issue to other members of the health care team, including a resident's doctor) Communication Form dated 3/11/2025, the SBAR Communication Form indicated Resident 16 was found on the floor next to her bed. The SBAR Communication Form further indicated Resident 16 stated she did not know what happened and that she was just trying to get comfortable. During a concurrent interview and record review on 3/13/2025 at 11:20 a.m., with Treatment Nurse 1 (TN 1) and the Director of Nursing (DON), reviewed Resident 16's Fall Risk Evaluations, dated 2/1/2025 and 3/11/2025. Resident 16's Fall Risk Evaluation dated 2/1/2025 indicated the second and third sections titled Gait/Balance, and Medications were blank. TN 1 stated he (TN 1) did Resident 16's Fall Risk Evaluation dated 2/1/2025 and should have completed all sections of the evaluation. Resident 16's Fall Risk Evaluation, dated 3/11/2025, indicated Resident 16 had no falls within the past three months. The DON stated Resident 16's Fall Risk Evaluation dated 3/11/2025 was completed after Resident 16's fall on the morning of 3/11/2025 and the Fall Risk Evaluation should indicate that the resident had a fall within the past three months. The DON stated it is important to accurately complete the Fall Risk Evaluations so they know the resident's risk of falling and staff can effectively care for the resident. During a review of the facility's policy and procedure (P&P) titled, Falls and Fall Risk, Managing, last revised 2/26/2025, the P&P indicated based on previous evaluations and current data, staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. 38549 Based on interview and record review, the facility failed to ensure licensed nurses attempted nonpharmacological interventions (treatments or therapies that do not involve the use of medications) prior to administering as needed (PRN) morphine sulfate (a drug used to treat moderate to severe pain) to one of one sampled resident (Resident 17) investigated under the care area of pain management. This deficient practice had the potential to place the resident at increased risk of experiencing adverse side effects (undesired harmful effect resulting from a medication or other intervention). Findings: During a review of Resident 17's Admission Record, the Admission Record indicated the facility originally admitted the resident on 10/20/2021 and readmitted the resident on 5/1/2024 for diagnoses including polyneuropathy (a condition that affects multiple peripheral nerves, which are the nerves outside the brain and spinal cord) and spinal enthesopathy in the lumbar region (a condition where the entheses [the points where tendons and ligaments attach to bone] in the lower back are affected, causing pain, stiffness, and potentially limited mobility). During a review of Resident 17's Minimum Data Set (MDS - a resident assessment tool) dated 2/20/2025, the MDS indicated the resident had moderately impaired cognition (thought processes) and was dependent on staff for most activities of daily living (ADLs - activities such as bathing, dressing, and toileting a person performs daily). During a concurrent interview and record review on 3/11/2025 at 2:17 p.m., with Registered Nurse 1 (RN 1), reviewed Resident 17's physician orders and Resident 17's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) dated 3/2025. RN 1 stated Resident 17 had an order for morphine sulfate 20 milligrams (mg - unit of measurement) per five (5) milliliters (ml - unit of measurement), give 0.25 ml sublingually (under the tongue) every two (2) hours as needed for severe pain 7 - 10 out of 10 (numerical scale used to measure pain with 0 being no pain and 10 being the worst pain) or shortness of breath (SOB), ordered on 8/9/2024. RN 1 stated Resident 17 had an order for nonpharmacological interventions, ordered on 3/2/2025. RN 1 stated Resident 17's MAR indicated the following: - On 3/1/2025 at 2:21 a.m., Resident 17 received morphine sulfate 0.25 mg, but there is no documentation indicating that nonpharmacological interventions were attempted first. - On 3/1/2025 at 6:32 p.m., Resident 17 received morphine sulfate 0.25 mg, but there is no documentation indicating that nonpharmacological interventions were attempted first. - On 3/2/2025 at 6:30 p.m., Resident 17 received morphine sulfate 0.25 mg, but there is no documentation indicating that nonpharmacological interventions were attempted first. - On 3/4/2025 at 5 p.m., Resident 17 received morphine sulfate 0.25 mg, but there is no documentation indicating that nonpharmacological interventions were attempted first. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 3/6/2025 at 11:09 a.m., Resident 17 received morphine sulfate 0.25 mg, but there is no documentation indicating that nonpharmacological interventions were attempted first. - On 3/7/2025 at 8:28 p.m., Resident 17 received morphine sulfate 0.25 mg, but there is no documentation indicating that nonpharmacological interventions were attempted first. - On 3/10/2025 at 11 a.m., Resident 17 received morphine sulfate 0.25 mg, but there is no documentation indicating that nonpharmacological interventions were attempted first. During an interview on 3/12/2025 at 11:07 a.m., with the Director of Nursing (DON), the DON stated that licensed nurses should be attempting nonpharmacological interventions prior to administering opioid medications (medications used for moderate to severe pain) because it may possibly relieve the resident's pain, and the resident may not need the medication. During a review of the facility's policy and procedure titled, Pain Assessment and Management, last reviewed on 2/26/2025, the policy and procedure indicated that nonpharmacological interventions may be appropriate alone or in conjunction with medications.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38549 Based on interview and record review, the facility failed to provide trauma-informed care (an approach to delivering care that involves understanding, recognizing and responding to the effects of all types of trauma) to a resident with a diagnosis of post-traumatic stress disorder (PTSD - a disorder in which a person has difficulty recovering after experiencing or witnessing a traumatic event) by failing to complete a timely trauma-informed care assessment and conduct an 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) meeting to address the resident's specific needs for one of one sampled resident (Resident 49) investigated under the care area of trauma-informed care. This deficient practice had the potential to place the resident at increased risk of being triggered by and experiencing symptoms of their PTSD. Findings: During a review of Resident 49's Admission Record, the Admission Record indicated the facility admitted the resident on 1/31/2025 with diagnoses including PTSD. During a review of Resident 49's Minimum Data Set (MDS - a resident assessment tool) dated 2/4/2025, the MDS indicated the resident had moderately impaired cognition (thought processes) and required moderate assistance from staff for most activities of daily living (ADLs - activities such as bathing, dressing, and toileting a person performs daily). The MDS also indicated the resident has a diagnosis of PTSD. During a review of Resident 49's Trauma Informed Care assessment dated [DATE], the assessment indicated that Resident 49 has experienced trauma. During a concurrent interview and record review on 3/11/2025 at 4:34 p.m., with Registered Nurse 1 (RN 1), reviewed Resident 49's IDT progress notes dated 2/4/2025 to 3/11/2025. RN 1 stated he (RN 1) could not find any IDT progress notes addressing Resident 49's PTSD. During an interview on 3/12/2025 at 10:34 a.m., with Licensed Vocational Nurse 2 (LVN 2), LV 2 stated she (LVN 2) was from the facility's regional office and was the one who completed Resident 49's Trauma Informed Care assessment dated [DATE]. When asked what prompted her to complete Resident 49's Trauma Informed Care Assessment, LVN 2 stated that Medical Records was doing an audit and had asked her (LVN 2) to complete the assessment. LVN 2 stated it should have been done upon Resident 49's admission. During an interview on 3/12/2025 at 11:18 a.m., with the Director of Nursing (DON), the DON stated that Social Services should be completing the Trauma Informed Care Assessment for all residents. The DON stated there should have also been an IDT meeting to discuss the specific care that a resident diagnosed with PTSD would need. The DON stated it was important to discuss the resident's specific triggers so that the facility could provide care around avoiding those triggers. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/12/2025 at 11:37 a.m., with the Social Services Designee (SSD), the SSD stated that her previous director had been the one responsible for doing the Trauma Informed Care Assessments for all residents upon admission. The SSD stated she had no experience doing the assessment. During a review of the facility's policy and procedure titled, Trauma Informed Care and Culturally Competent Care, last reviewed on 2/26/2025, the policy and procedure indicated that the purpose of the policy was to address the needs of trauma survivors by minimizing triggers and/or re-traumatization. Develop an organizational culture that supports all Trauma-Informed and Resilience Oriented domains. These include universal and early screening and assessment, etc. Assessment involves an in-depth process of evaluating the presence of symptoms, their relationship to trauma, as well as the identification of triggers.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44309 Based on interview and record review, the facility failed to follow its policy and procedure titled, Social Assessment, for one of two sampled residents (Resident 18) by failing to conduct a social service assessment within 14 days of the resident's admission to the facility. This deficient practice had the potential for the resident not to attain the highest practicable physical, mental, and psychosocial well-being and delay in the delivery of care and services. Findings: During a review of Resident 18's Admission Record, the Admission Record indicated that the facility admitted the resident on 2/12/2025 with diagnoses including type two (2) diabetes mellitus (DM- a chronic condition that affects the way the body processes blood glucose [sugar]), paranoid schizophrenia (type of schizophrenia [a mental illness that is characterized by disturbances in thought] accompanied by paranoia [way of thinking that involves feelings of distrust and suspicion about others without a good reason]), and encephalopathy (a general condition characterized by impaired brain function). During a review of Resident 18's History and Physical (H&P- a formal assessment by a healthcare provider that involves a resident interview, physical exam, and documentation of findings) dated 2/13/2025, the H&P indicated that the resident had the capacity to understand and make decisions. During a review of Resident 18's Minimum Data Set (MDS - a resident assessment tool) dated 2/19/2025, the MDS indicated that the resident's cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was moderately impaired. The MDS indicated that Resident 18 required staff partial/moderate assistance (helper does less than half the effort) for oral hygiene, toileting hygiene, lower body dressing, showering and bathing, putting on/talking off footwear, and personal hygiene. During a concurrent interview and record review on 3/12/2025 at 2:36 p.m., with the Social Services Designee (SSD), reviewed Resident 18's Social Service Assessments from 2/12/2025 to 3/12/2025. The SSD stated that Resident 18 was admitted to the facility on [DATE], however, the facility did not conduct any social service assessments for Resident 18 since their admission. The SSD stated she (SSD) was not in charge of conducting social service assessments at that time, and there was another social worker in charge, however, the SSD stated that she (SSD) should have followed up and conducted the initial social service assessments for the residents missing theirs. The SSD stated the social workers are required to meet with the residents or their families upon admission and gather information necessary to conduct an initial assessment within 14 days of the resident's admission. The SSD stated that this assessment includes psychosocial history, physical, cultural and spiritual factors having impact on the resident's adjustment and wellbeing in the facility, and the determination of anticipated discharge planning. The SSD stated that this information was not gathered for Resident 18 since his admission to the facility. The SSD stated that the potential outcome of not timely assessing a resident is the delay in addressing their psychosocial issues and assisting the residents with their adjustment period in the facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555578	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2025
NAME OF PROVIDER OR SUPPLIER Holiday Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 20554 Roscoe Blvd Canoga Park, CA 91306	

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/13/2025 at 2:30 p.m., with the Director of Nursing (DON), the DON stated the social worker should visit the residents upon their admission into the facility and shall conduct a social service assessment within 14 days of the resident's admission. The DON stated staff did not conduct any social service assessments for Resident 18 and the potential outcome is the inability to address psychosocial concerns, prevent psychosocial issues, provide safe discharge, and assist residents with their adjustment period in the facility. During review of the facility's policy and procedure (P&P) titled, Social Assessments, last reviewed on 2/26/2025, the P&P indicated that a social assessment shall be completed within 14 days of the resident's admission to the facility. A social assessment will be done to help identify the resident's personal and social situation, needs, and problems. Social services staff will obtain information during the initial interview of the family and upon the resident's admission. The purpose of obtaining this data is to identify information to help staff develop a personalized plan of care that will utilize the individual's existing strengths, try to compensate for physical and functional deficits, optimize function and quality of life, and meet the individual's needs and preferences.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38549 Based on interview and record review, the facility failed to: 1. Ensure licensed nurses documented on the Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) after administering as needed (PRN) tramadol (medication used for moderate to severe pain) for one of two sampled residents (Resident 29). 2. Ensure licensed nurses documented on the MAR after administering PRN oxycodone (medication used to treat moderate to severe pain) for one of two sampled residents (Resident 8). This deficient practice had the potential to place the residents at increased risk of being given extra doses of a narcotic medication (medications used to treat moderate to severe pain) leading to an increased risk of the residents experiencing adverse side effects (undesired harmful effect resulting from a medication or other intervention). Findings: 1. During a review of Resident 29's Admission Record, the Admission Record indicated the facility originally admitted the resident on 9/20/2024 and readmitted the resident on 1/24/2025 with diagnoses including polyneuropathy (a condition in which multiple peripheral nerves [nerves outside the brain and spinal cord] are damaged) and bilateral (both sides) osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage) of the knees. During a review of Resident 29's Minimum Data Set (MDS - a resident assessment tool) dated 12/23/2024, the MDS indicated the resident had intact cognition (thought processes) and required supervision for most activities of daily living (ADLs - activities related to personal care). During a concurrent interview and record review on 3/11/2025 at 11:52 a.m., with Registered Nurse 2 (RN 2), reviewed Resident 29's physician orders, Resident 29's Record of Controlled Substances, and Resident 29's MAR dated 3/2025. RN 2 stated Resident 29 had an order for tramadol 50 milligrams (mg - unit of measurement) by mouth (PO) every six (6) hours as needed for chronic pain for 10 days, ordered on 2/23/2025. RN 2 stated that on 3/7/2025 at 12 p.m., the licensed nurse documented on Resident 29's Record of Controlled Substances that tramadol was taken out of the bubble pack (plastic packaging in which a medication is stored until ready for use) but did not document on Resident 29's MAR that it was administered. RN 2 stated that the Record of Controlled Substances should coincide with the MAR to ensure that the next shift nurse knows that the medication was actually administered to the resident. RN 2 stated that if it is not recorded as being given on the MAR, then there is a risk that the resident can receive a double dose of the medication. During an interview on 3/12/2025 at 11:07 a.m., with the Director of Nursing (DON), the DON stated it was important for licensed nurses to also document when a medication was administered on the MAR so that other nurses knew whether or not a narcotic medication had been administered already. (continued on next page)

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	03/13/2025

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 0755

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

During a review of the facility's policy and procedure titled, Administering Medications, last reviewed on 2/26/2025, the policy and procedure indicated that the individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones.

2. During a review of Resident 8's Admission Record, the Admission Record indicated the facility originally admitted the resident on 8/28/2020 and readmitted the resident on 9/9/2024 with diagnoses including idiopathic peripheral autonomic neuropathy (nerve damage in the autonomic nervous system [which controls involuntary functions]), chronic ulcer (a small open sore or wound generally found in the stomach or on the skin) on the right foot, osteoarthritis, and dorsalgia (pain in the back, specifically in the mid-back).

During a review of Resident 8's MDS dated [DATE], the MDS indicated the resident had moderately impaired cognition and was independent for most ADLs.

During a concurrent interview and record review on 3/11/2025 at 11:38 a.m., with RN 2, reviewed Resident 8's physician orders, Resident 8's Record of Controlled Substances, and Resident 8's MAR dated 3/2025. RN 2 stated Resident 8 had an order for oxycodone 30 mg PO every six (6) hours as needed for severe pain (7-9/10- numerical scale used to measure pain with 0 being no pain and 10 being the worst pain), ordered on 9/9/2024. RN 2 stated that the licensed nurse documented on Resident 8's Record of Controlled Substances that oxycodone was taken out of the bubble pack on 3/7/2025 at 12:30 p.m. and 3/8/2025 at 4 p.m., but they were not documented on Resident 8's MAR as being administered. RN 2 stated that the Record of Controlled Substances should coincide with the MAR to ensure that the next shift nurse knows that the medication was actually administered to the resident. RN 2 stated that if it is not recorded as being given on the MAR, then there is a risk that the resident can receive a double dose of the medication.

During an interview on 3/12/2025 at 11:07 a.m., with the DON, the DON stated it was important for licensed nurses to also document when a medication was administered on the MAR so that other nurses knew whether or not a narcotic medication had been administered already.

During a review of the facility's policy and procedure titled, Administering Medications, last reviewed on 2/26/2025, the policy and procedure indicated that the individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555578	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2025
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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** 38549 Based on interview and record review, the facility failed to: 1. Ensure licensed nurses attempted nonpharmacological interventions (treatments or therapies that do not involve the use of medications) prior to administering as needed (PRN) lorazepam (used to treat anxiety disorder [a mental health condition characterized by persistent and excessive worry or fear that interferes with daily life]) for one of two sampled residents (Resident 29). 2 Ensure the physician's order for a resident's PRN lorazepam had a stop date (the date on which a specific medication or treatment order, as written by a physician, is scheduled to be discontinued unless the physician extends or modifies the order) for one of five sampled residents (Resident 17). These deficient practices had the potential to place the resident at increased risk of taking an unnecessary medication and experiencing adverse side effects (undesired harmful effect resulting from a medication or other intervention). Findings: 1. During a review of Resident 29's Admission Record, the Admission Record indicated the facility originally admitted the resident on 9/20/2024 and readmitted the resident on 1/24/2025 with diagnoses including anxiety disorder. During a review of Resident 29's Minimum Data Set (MDS - a resident assessment tool) dated 12/23/2024, the MDS indicated the resident had intact cognition (thought processes) and required supervision for most activities of daily living (ADLs - activities related to personal care). During a concurrent interview and record review on 3/11/2025 at 11:52 a.m., with Registered Nurse 2 (RN 2), reviewed Resident 29's physician orders and Resident 29's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) dated 3/2025. RN 2 stated Resident 29 had an order for lorazepam 0.5 milligrams (mg - unit of measurement) by mouth (PO) every four (4) hours as needed for anxiety manifested by agitation leading to shortness of breath (SOB) for 14 days, ordered on 3/1/2025. RN 2 stated Resident 29's MAR dated 3/2025 indicated the following: - On 3/1/2025 at 9 p.m., Resident 29 received lorazepam, but there is no documentation indicating that nonpharmacological interventions were attempted first. - On 3/3/2025 at 9:06 a.m., Resident 29 received lorazepam 0.5 mg, but there is no documentation indicating that nonpharmacological interventions were attempted first. - On 3/5/2025 at 4:37 a.m., Resident 29 received lorazepam 0.5 mg, but there is no documentation indicating that nonpharmacological interventions were attempted first. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Holiday Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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	- On 3/11/2025 at 9:15 a.m., Resident 29 received lorazepam 0.5 mg, but there is no documentation indicating that nonpharmacological interventions were attempted first. During an interview on 3/12/2025 at 11:07 a.m., with the Director of Nursing (DON), the DON stated that nurses should be attempting nonpharmacological interventions prior to administering PRN medications because it may possibly relieve the resident's symptoms, and the resident may not need the medication. During a review of the facility's policy and procedure titled, Psychotropic Medication Use, last reviewed on 2/26/2025, the policy and procedure indicated that nonpharmacological approaches are used (unless contraindicated) to minimize the need for medications, permit the lowest possible dose, and allow for discontinuation of medications when possible. 2. During a review of Resident 17's Admission Record, the Admission Record indicated the facility originally admitted the resident on 10/20/2021 and readmitted the resident on 5/1/2024 with diagnoses including chronic obstructive pulmonary disorder (COPD - a chronic lung disease causing difficulty in breathing). During a review of Resident 17's MDS dated [DATE], the MDS indicated the resident had moderately impaired cognition and was dependent on staff for most ADLs. During a concurrent interview and record review on 3/11/2025 at 2:20 p.m., with Registered Nurse 1 (RN 1), reviewed Resident 17's physician orders. RN 1 stated Resident 17 had an order for lorazepam 2 mg per milliliter (ml - unit of measurement), give 0.25 ml sublingually (under the tongue) every four (4) hours as needed for anxiety manifested by verbalization of feeling anxious, ordered on 2/5/2025. RN 1 stated there was no stop date for Resident 17's lorazepam order. During an interview on 3/12/2025 at 11:24 a.m., with the DON, the DON stated that PRN lorazepam should have a stop date after 14 days. The DON stated that, after 14 days, the physician needs to reevaluate if the resident needs to be continued on the medication. During a review of the facility's policy and procedure titled, Psychotropic (medications capable of affecting the mind, emotions, and behavior) Medication Use, last reviewed on 2/26/2025, the policy and procedure indicated that PRN orders for psychotropic medications are limited to 14 days. For psychotropic medications that are not antipsychotics (a medication used to treat psychosis [a mental condition in which thought, and emotions are so affected that contact is lost with external reality]), if the prescriber or attending physician believes it is appropriate to extend the PRN order beyond 14 days, he or she will document the rationale for extending the use and include the duration for the time.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 47883 Based on observation, interview and record review, the facility failed to ensure residents were free from any significant medication errors for one of five sampled residents (Resident 34) by failing to administer clozapine (medication used to treat schizophrenia [mental disorder in which people interpret reality abnormally]) as ordered. This deficient practice had the potential for the medication to not be effective or cause adverse reaction (undesired harmful effect resulting from a medication or other intervention) to Resident 34. Findings: During a review of Resident 34's Admission Record, the Admission Record indicated the facility admitted the resident on 12/18/2019 and readmitted the resident on 5/9/2024 with diagnoses that included encephalopathy (brain disease, damage, or malfunction of brain), paranoid schizophrenia (type of schizophrenia accompanied by paranoia [way of thinking that involves feelings of distrust and suspicion about others without a good reason]), and major depression (a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with your daily activities of living). During a review of Resident 34's Minimum Data Set (MDS, a resident assessment tool) dated 12/12/2024, the MDS indicated Resident 34 had mildly impaired cognition (thought processes). During a review of History and Physical (H&P- a formal assessment by a healthcare provider that involves a resident interview, physical exam, and documentation of findings) dated 5/9/2024, the H&P indicated that Resident 34 had capacity to understand and make decisions. During a review of Resident 34's Order Summary Report, the Order Summary Report indicated an order for clozapine orally disintegrating tablet (ODT) 200 milligrams (mg- unit of measurement) give one tablet orally one time a day for schizophrenia paranoid type. During a medication administration observation on 3/11/2025 at 9:48 a.m., with Licensed Vocational Nurse 1 (LVN 1), observed LVN 1 administer clozapine ODT 100 mg two tablets to Resident 34 without explaining to Resident 34 to allow the tablets to disintegrate in the mouth and swallow with saliva or chew as desired. During an interview on 3/11/2025 at 10:00 a.m., with LVN 1, LVN 1 stated that she (LVN 1) is not sure what the abbreviation ODT meant and how to correctly administer ODT medication. During a concurrent interview and record review on 3/11/2025 at 12:05 p.m., with the Assistant Director of Nursing (ADON), reviewed the administration manual for clozapine ODT. The ADON stated that the medication has to be dissolved in the mouth before swallowing. The ADON stated that licensed staff that are administering medication to the residents should be knowledgeable about right route of medication administration. (continued on next page)

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

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/12/2025 at 1:14 p.m., with Pharmacist 1 (P 1), P 1 stated that ODT medication has to be disintegrated in the mouth before swallowing. During an interview on 3/13/2025 at 3:47 p.m., with the Director of Nursing (DON), the DON stated that staff have to administer medication according to the physician order including right route of administration to enhance optimal therapeutic effect of the medication. During a review of the facility's policy and procedure titled, Administration Medications, last reviewed 2/26/2025, the policy indicated medications are administered in a safe and timely manner including right method (route) of administration, and as prescribed to enhance optimal therapeutic effect of the medication.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50033 Based on observation, interview, and record review, the facility failed to store unopened insulin (hormone that lowers the level of glucose [sugar] in the blood) pens (a medical device used to inject insulin subcutaneously [SQ - administering medication where a short needle is used to inject a medication into the tissue layer between the skin and the muscle]) inside the refrigerator for two of two sampled residents (Resident 80 and 391). This deficient practice had the potential for the insulin to lose efficacy and can result in uncontrolled blood glucose. Findings: 1. During a review of Resident 80's Admission Record, the Admission Record indicated the facility originally admitted the resident on 1/21/2024 and readmitted the resident on 12/16/2024 with diagnoses including type two (2) diabetes mellitus (DM - a chronic condition that affects the way the body processes blood glucose [sugar]) with ketoacidosis (a complication of diabetes in which acids build up in the blood to levels that can be life-threatening). During a review of Resident 80's Minimum Data Set (MDS - a resident assessment tool) dated 1/16/2025, the MDS indicated Resident 80 had impaired cognition (thought processes). The MDS further indicated Resident 80 required supervision or touching assistance with most activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 80's physician orders dated 12/16/2024, the physician order indicated an order to administer insulin glargine (long-acting insulin) 100 units/milliliter (U/ml- unit of measurement), inject 25 units subcutaneously at bedtime for DM. During a concurrent observation and interview on 3/12/2025 at 11:55 p.m., with Licensed Vocational Nurse 1 (LVN 1), observed Resident 80's unopened insulin glargine pen inside Medication Cart A. Observed a sticker on Resident 80's insulin pen packaging which indicated to refrigerate unopened pens. LVN 1 stated Resident 80's insulin pen should be stored in the refrigerator. LVN 1 further stated insulin can only be out of the refrigerator for 28 days before they need to discard the medication and request a new one from the pharmacy so they can ensure the insulin works as intended. 38549 2. During a review of Resident 391's Admission Record, the Admission Record indicated the facility originally admitted the resident on 1/30/2020 and readmitted the resident on 1/26/2025 with diagnoses including type 2 diabetes mellitus. During a review of Resident 391's MDS dated [DATE], the MDS indicated the resident had moderately impaired cognition. The MDS also indicated Resident 391 received insulin. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555578	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2025
NAME OF PROVIDER OR SUPPLIER Holiday Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 20554 Roscoe Blvd Canoga Park, CA 91306	

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 391's physician orders dated 1/26/2025, the physician orders indicated an order to administer insulin glargine 100 units/milliliter, inject 20 units subcutaneously at bedtime for DM. During a concurrent observation and interview on 3/11/2025 at 11:15 a.m., with Registered Nurse 2 (RN 2), observed Resident 391's unopened insulin glargine pen inside Medication Cart B. Observed a sticker on Resident 391's insulin pen packaging indicating to refrigerate if unopened. During an interview on 3/12/2025 at 11:15 a.m., with the Director of Nursing (DON), the DON stated that unopened insulin should be stored in the refrigerator. The DON stated it was important to follow the manufacturer's guidelines in how to store the insulin because the temperature can affect the medication. The DON stated not refrigerating the insulin can cause it to lose efficacy, which in turn can cause it to have less of an effect for the resident. During a review of the facility-provided insulin glargine manufacturer's guide, the manufacturer's guide indicated to keep new pens in the refrigerator between 36 to 46 degrees Fahrenheit (unit of measurement). During a review of the facility's policy and procedure titled, Medication Labeling and Storage, last reviewed on 2/26/2025, the policy and procedure indicated that the facility stores all medications and biologicals in locked compartments under proper temperature, humidity, and light controls. Medications requiring refrigeration are stored in a refrigerator located in the medication room at the nurses' station or other secured location

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555578	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2025
NAME OF PROVIDER OR SUPPLIER Holiday Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 20554 Roscoe Blvd Canoga Park, CA 91306	

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50033 Based on observation, interview, and record review, the facility failed to follow safe food handling practices when Dietary Aide 1 (DA 1) was wearing an uncovered, dangling bracelet in the kitchen. This deficient practice had the potential to place 89 out of 90 residents who receive food from the facility's kitchen at risk for foodborne illnesses (refers to illness caused by the ingestion of contaminated food or beverages). Findings: During a concurrent observation and interview on 3/12/2025 at 12:08 p.m., in the facility's kitchen with the Dietary Supervisor (DS), observed DA 1 wearing a bracelet while taking plates from the steam table and putting them into a delivery cart. Observed DA 1's bracelet not covered by the gloves DA 1 was wearing. The DS stated they do not usually wear bracelets in the kitchen. During a concurrent interview and record review on 3/13/20254 at 9:35 a.m., with the DS, reviewed the facility's policy and procedure (P&P) titled, Dress Code for Women and Men, dated 2018. The policy indicated no excessive jewelry should be worn. The policy further indicated only wedding rings, non-dangling earrings, and a wristwatch could be worn, and wedding rings and wristwatches must be covered with gloves when handling food. The DS stated the dress code should be followed to maintain cleanliness in the kitchen.

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 47883 Based on observation, interview, and record review, the facility failed to: 1. Implement its policy titled, Enhanced Barrier Precautions (EBP - a set of infection control practices that use personal protective equipment [PPE - equipment worn to reduce exposure to hazards in the workplace] to reduce the spread of multidrug-resistant organisms [MDROs - microorganisms that are resistant to multiple classes of antibiotics and antifungals] in nursing homes) by failing to ensure one of one sampled resident (Resident 57) who had a colostomy bag (a medical device that collects stool from a surgical opening in the abdomen) was placed on EBP. This deficient practice had the potential to transmit infectious microorganisms to staff and other residents in the facility. 2. Ensure a resident's urinal (a bottle for collecting urine) was labeled with a resident identifier for one of five sampled residents (Resident 52) investigated for infection control. This deficient practice had the potential to place the resident at increased risk of contracting an infection. Findings: 1. During a review of Resident 57's Admission Record, the Admission Record indicated the facility admitted the resident on 2/7/2025 and readmitted the resident on 3/4/2025 with diagnoses including metabolic encephalopathy (condition where the brain's function is impaired due to an imbalance in the body's metabolism), urinary tract infections (UTI - an infection in the bladder/urinary tract), and colostomy status (surgical procedure that creates an opening in the abdominal wall to divert stool from the large intestine to an external bag). During a review of Resident 57's History and Physical (H&P- a formal assessment by a healthcare provider that involves a resident interview, physical exam, and documentation of findings), dated 3/5/2025, the H&P indicated that the resident had the capacity to understand and make decisions. During a review of Resident 57's Minimum Data Set (MDS, a resident assessment tool) dated 3/8/2025, the MDS indicated that the resident was mildly impaired in cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) with skills required for daily decision making. The MDS indicated that Resident 57 required supervision (helper sets up or cleans up; resident completes activity) with eating and moderate assistance with oral hydyne and upper body dressing and was totally dependent on two or more helpers for toileting hygiene, shower and lower body dressing. During a concurrent observation and interview on 3/10/2025 at 9:55 a.m., observed Resident 57 in her room in bed. Resident 57 stated that she has a colostomy bag. Observed no EBP signs or containers with gloves and gowns outside of Resident 57's room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555578	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2025
NAME OF PROVIDER OR SUPPLIER Holiday Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 3/12/2025 at 10:58 p.m., with the Infection Preventionist (IP), reviewed Resident 57's physician orders and care plans and stated that there was no physician order to place Resident 57 on EBP and no care plan regarding Resident 57 requiring EBP due the colostomy bag. The IP stated she was not aware that a resident who has a colostomy required EBP to be initiated. The IP stated there were no EBP signs before the entrance into Resident 57's room and no PPE outside of Resident 57's room. The IP stated it was important to follow the facility's EBP policy to prevent transmission of infectious microorganisms to the other residents. During an interview on 3/13/2025 at 3:47 p.m., with the Director of Nursing (DON), the DON stated that it was important to put Resident 57 on EBP for infection control. During a review of the facility's policy and procedure titled, Enhanced Barrier Precautions, last reviewed on 2/26/2025, the policy and procedure indicated, Enhanced barrier precautions (EBP) are utilized to prevent the spread of multi-drug-resistant organisms .EBPs are indicated for residents with wounds and /or indwelling medical devices regardless of MDRO (multi-drug-resistant organisms) colonization. 38549 2. During a review of Resident 52's Admission Record, the Admission Record indicated the facility admitted the resident on 6/4/2024 with diagnoses including a history of urinary tract infections (UTI - an infection in the bladder/urinary tract). During a review of Resident 52's H&P dated 6/4/2024, the H&P indicated that the resident had the capacity to understand and make decisions. During a concurrent observation and interview on 3/10/2025 at 9:29 a.m., with Certified Nursing Assistant 4 (CNA 4), observed an unlabeled urinal at Resident 52's bedside. CNA 4 verified by stating that the urinal was not labeled with a resident identifier. During an interview on 3/12/2025 at 11:30 a.m., with the DON, the DON stated the facility had no specific policy addressing the labeling of urinals for infection control. During an interview on 3/12/2025 at 12:33 p.m., with the IP, the IP stated that residents' urinals should be labeled with their last name and first initial to ensure infection control. The IP stated it was important to label urinals with a resident identifier to ensure that only one resident is using it and there is no cross contamination amongst residents. During a review of the facility's policy and procedure titled, Infection Control Guidelines for All Nursing Procedures, last reviewed on 2/26/2025, the policy and procedure indicated that standard precautions (set of infection control practices designed to prevent the transmission of infectious diseases in healthcare settings) will be used in the care of all residents in all situations regardless of suspected or confirmed presence of infectious diseases. Standard precautions apply to blood, body fluids, secretions, and excretions regardless of whether or not they contain visible blood, non-intact skin, and/or mucous membranes. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555578	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure titled, Standard Precautions, last reviewed on 2/26/2025, the policy and procedure indicated that standard precautions will be used in the care of all residents regardless of their diagnoses or suspected or confirmed infection status. Standard Precautions presume that all blood, body fluids, secretions, and excretions (except sweat), non-intact skin and mucous membranes may contain transmissible infectious agents. Handle used resident-care equipment soiled with blood, body fluids, secretions, and excretions in a manner that prevents skin and mucous membrane exposures, contamination of clothing, and transfer of other microorganisms to other residents and environments.