

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555822	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2025
NAME OF PROVIDER OR SUPPLIER Canyon Oaks Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 22029 Saticoy Street Canoga Park, CA 91303	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.</p> <p>Based on interview and record review, the facility failed to ensure one of four sampled residents (Resident 1) was free from unnecessary psychotropic drugs (medications capable of affecting the mind, emotions, and behavior) by failing to evaluate and summarize Resident 1's behavioral symptoms from 1/1/2025 to 5/31/2025 for Seroquel (a medication used to treat mental health conditions such as schizophrenia [a mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions] and bipolar disorder [a mental illness characterized by extreme shifts in mood, energy, and activity levels]).</p> <p>This deficient practice had the potential to result in Resident 1 receiving unnecessary psychotropic drugs potentially increasing Resident 1's risk of adverse reactions (undesired harmful effect resulting from a medication or other intervention).</p> <p>Findings:</p> <p>During a review of Resident 1's admission Record, the admission Record indicated that the facility admitted Resident 1 on 3/31/2023 with diagnoses that included dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life) and hypertension (abnormally high blood pressure).</p> <p>During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 3/27/2025, the MDS indicated that Resident 1's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was severely impaired. The MDS further indicated that Resident 1 required maximal assistance from staff with toileting hygiene, shower or bathing, lower body dressing, bed mobility (movement), and transferring.</p> <p>During a review of Resident 1's Physician's Progress Notes dated 5/23/2025, the Physician's Progress Notes indicated that Resident 1 is on Seroquel 12.5 milligrams (mg - a unit of measurement) by mouth at bedtime for psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality) and agitation (feeling of irritability, mental distress or severe restlessness) with dementia.</p> <p>During a review of Resident 1's Physician's Order dated 6/11/2024, the Physician's Order indicated to give Seroquel 12.5 mg by mouth at bedtime for psychosis as evidenced by hallucinations (a perception of sensory experiences that are not real, occurring in the absence of external stimuli) or agitation leading to aggression.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During further review of Resident 1's Physician Order dated 6/12/2024, the Physician's Order indicated to monitor episodes of psychosis as evidenced by agitation or aggression and hallucinations every shift.</p> <p>During a review of Resident 1's Psychotropic Drug Behavior Monitoring (PDBM) form for Seroquel, dated from 12/1/2024 to 12/31/2024 indicated as follows:</p> <ul style="list-style-type: none"> - Behavior: hallucination or agitation leading to aggression - Number of episodes per shift: <ul style="list-style-type: none"> a. 7 am to 3 pm shift: one (1) episode b. 3 pm to 11 pm shift: zero or no episodes c. 11 pm to 7 am shift: zero or no episodes <p>During a concurrent interview and record review on 6/4/2025 at 3:45 p.m., with Assistant Director of Nursing (ADON), Resident 1's PDBM from 12/1/2024 to 12/31/2024 was reviewed. The ADON stated that the last PDBM summary for Resident 1 was done in December 2024. The ADON stated that there was no behavioral symptoms summary done for Resident 1's use of Seroquel from 1/1/2025 to 5/31/2025. When the ADON was asked how the facility planned to evaluate the resident's behavior and determine the effectiveness of Seroquel in the absence of a monthly summary, the ADON stated that the facility might refer to the daily behavior monitoring documented in the Medication Administration Record (MAR - a document used to track and record the administration of medications and treatments to a resident). The ADON further stated that it would be difficult to compare and analyze behavioral trends without a consolidated monthly summary.</p> <p>During a concurrent interview and record review on 6/4/2025 at 5:25 p.m., with the Director of Nursing (DON), Resident 1's PDBM from 12/1/2024 to 12/31/2024 was reviewed. When the DON was asked whether the facility had an alternative system in place to utilize the behavioral data documented in the MAR for ongoing analysis and re-evaluation of the need for Seroquel, the DON stated that the facility relies on the monthly PDBM summary. The DON stated that the PDBM summary was not completed for the past five months for Resident 1.</p> <p>During a review of the facility's policy and procedure (P&P), titled Psychotropic Medication Use last reviewed on 1/15/2025, indicated, Resident do not receive psychotropic medications that are not clinically indicated and necessary to treat a specific documented in the medical record adequate monitoring for efficacy and adverse consequences If the resident's condition has not responded to treatment, or has declined despite treatment, the physician or practitioner will re-evaluate the medication, dose, and duration and document the rationale for the continued use of medication.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>Based on interview and record review, the facility failed to ensure complete and accurate documentation in the Medication Administration Record (MAR - a document used to track and record the administration of medications and treatments to a resident) for one of four sampled residents (Resident 1) by failing to document observed episodes of physical aggression on 5/21/2025.</p> <p>This deficient practice had the potential to result in inaccurate behavior information, inappropriate medication management, hinder evaluation of treatment effectiveness, and negatively impact the resident.</p> <p>Findings:</p> <p>During a review of Resident 1's admission Record, the admission Record indicated that the facility admitted Resident 1 on 3/31/2023 with diagnoses that included dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life) and hypertension (abnormally high blood pressure).</p> <p>During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 3/27/2025, the MDS indicated that Resident 1's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was severely impaired. The MDS further indicated that Resident 1 required maximal assistance from staff with toileting hygiene, shower or bathing, lower body dressing, bed mobility (movement), and transferring.</p> <p>During a review of Resident 1's Physician's Progress Notes dated 5/23/2025, the Physician's Progress Notes indicated that Resident 1 is on Seroquel 12.5 milligrams (mg - a unit of measurement) by mouth at bedtime for psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality) and agitation (feeling of irritability, mental distress or severe restlessness) with dementia.</p> <p>During a review of Resident 1's Physician's Order dated 6/11/2024, the Physician's Order indicated to give Seroquel 12.5 mg by mouth at bedtime for psychosis as evidenced by hallucinations (a perception of sensory experiences that are not real, occurring in the absence of external stimuli) or agitation leading to aggression.</p> <p>During further review of Resident 1's Physician Order dated 6/12/2024, the Physician's Order indicated to monitor episodes of psychosis as evidenced by agitation or aggression and hallucinations every shift.</p> <p>During a review of Resident 1's Situation, Background, Assessment, Recommendation (SBAR - a communication tool used by healthcare workers designed to facilitate clear and concise communication, ensuring important information is conveyed accurately and efficiently) Communication Form, dated 5/21/2025, timed at 11 a.m., completed by Licensed Vocational Nurse 1 (LVN 1), the SBAR Communication Form indicated a check mark under the physical aggression category in the Behavioral Evaluation Section.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1's MAR dated 5/21/2025, 7 a.m. to 3 p.m. shift, the MAR indicated that on 5/21/2025, during the day shift (7 a.m. to 3:00 p.m.), LVN 1 documented that there was no episode of psychosis as evidenced by agitation or aggression and hallucinations.</p> <p>During a concurrent interview and record review on 6/4/2025 at 12:57 p.m., with LVN 1, Resident 1's SBAR dated 5/21/2025 and Resident 1's MAR dated 5/12/2025 were reviewed. LVN 1 stated that she should have marked Yes for physical aggression in the MAR for 5/21/2025, however, she documented No which was incorrect. When asked about the consequences of incorrect documentation related to monitoring behavioral issues while on Seroquel, LVN 1 stated that if a licensed nurse fails to accurately document episodes of aggression or agitation, it becomes difficult to determine whether Seroquel is effectively managing Resident 1's symptoms.</p> <p>During a concurrent interview and record review on 6/4/2025 at 3:20 p.m., with Assistant Director of Nursing (ADON), Resident 1's SBAR dated 5/21/2025 and Resident 1's MAR dated 5/12/2025 were reviewed. The ADON stated that licensed nurses are expected to monitor and document any episodes of Resident 1's agitation or aggression during each shift in the MAR. The ADON further stated that inaccurate documentation of behavioral monitoring for residents on psychotropic medications (medications capable of affecting the mind, emotions, and behavior) could impact the assessment of medication effectiveness and, the resident's plan of care. The ADON stated that accurate documentation is essential.</p> <p>During a review of the facility's policy and procedure (P&P), titled Charting and Documentation last reviewed on 1/15/2025, indicated, The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care Changes in the resident's condition Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.</p>		