STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555822	A. Building B. Wing	07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canyon Oaks Nursing and Rehabilitation Center	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)
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. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that two of three sampled residents (Resident 3 and Resident 4) received the necessary treatment and services to promote healing and/or prevent pressure ulcer or injuries (PU/Is- injury to skin and underlying tissue resulting from prolonged pressure on the skin) when on 7/24/2025 staff placed multiple layers of linen over the residents' low air loss mattresses (LALM - a mattress composed of inflatable air cushions that is used to relieve pressure on body parts), compromising the effectiveness of the pressure-relieving support surfaces. This deficient practice placed the residents at increased risk of pressure ulcers/injuries worsening or developing further and delayed wound healing. 1. During a review of Resident 4's admission Record, the admission Record indicated the facility originally admitted Resident 4 on 8/30/2023 and readmitted on [DATE] with diagnoses including pressure induced deep tissue damage (a type of pressure ulcer that occurs when pressure or shear forces damage the underlying tissues) of the right heel and PU of sacral region (sacrum - at the bottom of the spine and lies between the fifth segment of the lumbar spine [L5] and the coccyx [tailbone]) Stage four (ST 4 - full thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone). During a review of Resident 4's Minimum Data Set (MDS - a resident assessment tool) dated 5/2/2025, the MDS indicated Resident 4's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and senses) skills for daily decision making were severely impaired. The MDS indicated that Resident 4 was dependent on staff for oral hygiene, toileting hygiene, personal hygiene, upper and lower body dressing, bed mobility (movement) and transfer. The MDS further indicated that Resident 4 was at risk for developing PUs/Is and had one or more unhealed PUs/Is. During a review of Resident 4's Physician Order Summary dated 3/16/2025, the Physician's Order Summary indicated an order for LALM with alternating mode and setting based on comfort or weight of the resident. During a review of Resident 4's Skin and Wound Evaluation (SWE) form dated 7/16/2025, the SWE indicated that Resident 4 had ST 4 PU on the sacrococcyx (refers to the fused bone formed by the sacrum and the coccyx) and the wound size area was 1. 2 by 2 centimeter (cm - a unit of measurement), length - 1.3 cm, width - 0.9 cm, depth - 1.3 cm, and undermining (a type of wound where the edges of the wound have separated from the surrounding healthy tissue, creating a pocket or area of tissue damage beneath the surface of the skin) - 1.6 cm. The SWE form indicated LALM was provided to Resident 4. During a concurrent observation and interview on 7/24/2025 at 2:22 p.m., with Certified Nursing Assistant 2 (CNA 2), observed Resident 4 laying on a LALM on top of multiple layers of linen between Resident 4 and the LALM; from the top of the LALM toward the resident skin, a fitted sheet, four layers of the bedsheet made by folding the bed sheet twice, and Resident 4 was wearing an adult incontinence brief. CNA 2 stated that only two layers of linen were permitted when using a LALM however, Resident 4 had a total of six layers of linen in use. During a concurrent observation and interview on 7/24/2025 at 2:37 p.m., with CNA 2 and Treatment Nurse 2 (TN 2), TN 2 observed that multiple layers of linen were being used with the LALM and observed a total of six layers. TN 2 stated that using excessive linen on a LALM could negatively impact the wound healing process. TN 2 stated that she (TN 2) would address the issue with CNA 2. 2. During a review of Resident 3's admission Record, the admission Record indicated the facility originally admitted Resident 3 on 7/14/2022 and readmitted on [DATE] with diagnoses including cerebral infarction (CI - a serious medical condition that occurs when blood flow to the brain is blocked, leading to brain cell death) and dementia (a progressive state of decline in mental abilities). During a review of Resident 3's MDS dated [DATE], the MDS indicated Resident 3's cognitive skills for daily decision making were severely impaired. The MDS indicated that Resident 3 was dependent on staff for eating, oral hygiene, toileting hygiene, personal hygiene, upper and lower body dressing, bed mobility and transfer. The MDS further indicated that Resident 3 was at risk for developing PUs/Is. During a review of Resident 3's Physician Order Summary dated 7/24/2025, the Physician's Order Summary indicated an order for LALM with alternating mode and setting based on comfort or weight of the resident. During a review of Resident 3's Care Plan Report (untitled), which was initiated on 4/17/2024 and last revised on 2/18/2025, the Care Plan Report indicated that Resident 3 had a history of ST 4 PU to the sacrococcyx and was at risk for slow or delayed healing and/or further decline in skin integrity. Resident 4 was on a LALM, and the family preferred the use of briefs instead of breathable pads. The LALM protocol indicated only one sheet, one breathable pad, and one sheet to cover the resident were permitted. During a concurrent observation and

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview, and record review, the facility failed to ensure a resident who was incontinent (having no or insufficient voluntary control) of bladder and bowel (B&B) function, received appropriate care and services for one of four sampled residents (Resident 1) by failing to implement its policy and procedures (P&P) on Perineal (the area of the body between the anus and the genitals) Care when Certified Nursing Assistant (CNA 3) used a soiled towel to wipe the perineal area and did not rinse the perineal area while providing perineal care. This deficient practice had the potential to result in urinary tract infection (UTI- an infection in any part of the urinary system), skin irritation, and unpleasant odor.During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 3/4/2025 with diagnoses including malignant (to describe a cancerous tumor or a very serious medical condition) neoplasm (an abnormal growth of tissue) of right female breast and secondary malignant neoplasm of brain. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 5/15/2025, the MDS indicated Resident 1's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and senses) skills for daily decision making were intact. The MDS indicated that Resident 1 was dependent on staff for toileting hygiene and shower, required maximal assistance from staff with lower body dressing, and moderate assistance from staff with toilet transfer. The MDS further indicated Resident 1 was frequently incontinent of bladder (urine), occasionally incontinent of bowel, and at risk for developing pressure ulcer or injury (PU/I - injury to skin and underlying tissue resulting from prolonged pressure on the skin). During a concurrent observation and interview on 7/25/2025 at 10:21 a.m., with Certified Nursing Assistant 3 (CNA 3), observed CNA 3 providing perineal care to Resident 1 while Resident 1 was in bed. CNA 3 prepared a big towel by wetting it in the bathroom within Resident 1's room and placed it in a basin. During perineal care, observed CNA 3 used the same towel throughout the process. CNA 3 first wiped the front perineal area, then folded the towel and proceeded to wipe away bowel movement (BM). CNA 3 continued using the same towel, refolding it to use different sections - first to clean the front perineal area and then again to wipe the anal and buttocks area. CNA 3 did not rinse or dry Resident 1's perineal area during perineal care. When CNA 3 was further interviewed after completing Resident 1's perineal care, CNA 3 stated that only one big wet towel with warm water was used to clean Resident 1's perineal area from front to back following an episode of bladder and bowel incontinence. During a concurrent interview on 7/25/2025 at 10:49 a.m., with CNA 3, the Infection Preventionist (IP), and the Director of Nursing (DON), in the conference room, CNA 3 described the proper clinical procedures for perineal care and stated that a separate towel with soap and water should have been used to clean the front and back areas of the perineal area. However, CNA 3 stated that she (CNA 3) only used one big wet towel during Resident 1's perineal care. The DON stated that CNA 3 was aware of the correct perineal care procedures but failed to follow while providing perineal care to Resident 1. During a review of the facility's P&P titled, Perineal Care last reviewed on 1/15/2025, the P&P indicated, The purpose of this procedure is to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin conditions. Wet washcloth and apply soap or skin cleansing agent. Gently dry perineum. Wash the rectal area thoroughly, wiping from the base of the labia towards and extending over the buttock. Rinse and dry thoroughly.

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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. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to implement infection control practices by failing to ensure one of four sampled staff (Certified Nursing Assistant 3 [CNA 3]) performed hand hygiene (HH -cleaning hands by either washing with soap and water, or by using a hand sanitizing [removing germs] gel) after providing Resident 1's perineal (the area of the body between the anus and the genitals) care and before touching Resident 1's body to change the resident's clothing and position while in the bed. These deficient practices had the potential to result in the spread of infection placing residents, staff, and visitors at risk of being infected with germs. During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 3/4/2025 with diagnoses including malignant (to describe a cancerous tumor or a very serious medical condition) neoplasm (an abnormal growth of tissue) of right female breast and secondary malignant neoplasm of brain. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 5/15/2025, the MDS indicated Resident 1's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and senses) skills for daily decision making were intact. The MDS indicated that Resident 1 was dependent on staff for toileting hygiene and shower, required maximal assistance from staff with lower body dressing, and moderate assistance from staff with toilet transfer. The MDS further indicated Resident 1 was frequently incontinent of bladder (urine), occasionally incontinent of bowel, and at risk for developing pressure ulcer or injury (PU/I - injury to skin and underlying tissue resulting from prolonged pressure on the skin). During a concurrent observation and interview on 7/25/2025 at 10:21 a.m., with Certified Nursing Assistant 3 (CNA 3), observed CNA 3 providing perineal care to Resident 1 while Resident 1 was in bed. CNA 3 prepared a big towel by wetting it in the bathroom within Resident 1's room and placed it in a basin. During perineal care, observed CNA 3 used the same towel throughout the process. CNA 3 first wiped the front perineal area, then folded the towel and proceeded to wipe away bowel movement (BM). CNA 3 continued using the same towel, refolding it to use different sections - first to clean the front perineal area and then again to wipe the anal and buttocks area. CNA 3 began assisting Treatment Nurse 3 (TN 3) with wound dressing changes without performing HH or changing into new gloves. After TN 3 completed the wound dressing changes for Resident 1, CNA 3 covered Resident 1 with a new brief, changed into new clothing, and repositioned Resident 1. CNA 3 performed HH after discarding the soiled brief and linen, which were placed in a plastic bag. When CNA 3 was asked how many times HH was performed from the start of Resident 1's perineal care to the completion of the brief and clothing change, CNA 3 stated that she performed HH once before starting Resident 1's perineal care and once after discarding Resident 1's soiled brief and linen. CNA 3 stated that HH was performed twice during the process of providing Resident 1's perineal care, including the change to the new brief and clothing. During a concurrent interview on 7/25/2025 at 10:49 a.m., with CNA 3, the Infection Preventionist (IP), and the Director of Nursing (DON), in the conference room, CNA 3 stated that she was supposed to wash her hands and change gloves after cleaning Resident 1's perineal area, including the BM and after handling the soiled linens, before touching Resident 1's body, a new brief, or new clothing. However, CNA 3 performed HH twice during the process: once while providing Resident 1's perineal care and once after changing Resident 1 into the new brief and clothing. During an interview on 7/25/2025 at 11:08 a.m., the IP stated that CNA 3 did not perform HH after cleaning Resident 1's BM and before touching new things including the resident's body or clothing. The IP stated this failure to follow proper HH procedures violated the infection prevention control program and increased the risk of spreading the germs. During a review of the facility's policy and procedures (P&P) titled, Handwashing/Hand Hygiene last reviewed on 1/15/2025, the P&P indicated, The facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections. HH is indicated. after contact with blood, body fluids, or contaminated surface, after touching a resident. before moving from work on a soiled body site to clean body on the same resident, During a review of the facility's P&P titled, Infection Prevention and Control last reviewed on 1/15/2025, the P&P indicated, The facility adopted infection prevention and control policies and procedures are intended to help maintain a safe, sanitary, and comfortable environment and to help prevent and mange transmission of disease and infections. The extent of personal training on new or revised P&P is consistent with job responsibilities and complexity of the P&P, Competency demonstrations may be required for certain P&Ps,