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	08/25/2025

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 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. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1) received care and services in accordance with professional standards of practice by failing to administer Resident 1's insulin (hormone that regulate the amount of glucose [sugar] in the blood) as prescribed by the physician.This deficient practice resulted in the omission of insulin which could have resulted in a hyperglycemic (a condition where the blood sugar levels are abnormally high) episode.During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 7/17/2025 with diagnoses that included cerebral infarction (stroke, loss of blood flow to a part of the brain) due to occlusion (the blockage or closing of an opening, blood vessel) or stenosis (abnormal narrowing of a blood vessel) of small artery (tiny blood vessel), type two (2) diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing) without complications, and long term use of insulin. During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 8/6/2025, the MDS indicated the resident had severe cognitive (the mental process involved in knowing, learning, and understanding things) impairment. The MDS indicated Resident 1 required partial/moderate assistance from staff with eating, oral hygiene, required substantial/maximal assistance from staff personal hygiene, and is dependent on staff with toileting hygiene.During a review of Resident 1's Order Summary Report, the Order Summary Report indicated an order for insulin glargine solution 100 unit/milliliters (units/mL- unit of measurement), inject nine (9) units subcutaneously (under the skin) at bedtime for DM (hold if blood sugar [BS] less than 100 milligram/deciliter (mg/dL - units of measurement), ordered 8/7/2025. During a review of Resident 1's care plan (a document that summarizes a resident's needs, goals, and care/treatment), initiated 8/4/2025, the care plan indicated the resident has hyperglycemia related to DM. The care plan indicated an intervention for Lantus (brand name of insulin glargine) as ordered. During a concurrent interview and record review on 8/25/2025 at 12:06 p.m., with Registered Nurse 1 (RN 1), reviewed Resident 1's Medication Administration Record (MAR, a report detailing the medication administered to a resident by the licensed nurses) dated 8/2025. RN 1 stated all medications should be given per physician's order. RN 1 stated that Resident 1 did not receive his glargine insulin on 8/14/2025. RN 1 stated that Resident 1's blood sugar on 8/14/2025 at 9:00 p.m. was 100 mg/dL. RN 1 stated Resident 1's blood sugar was within parameters (a set of defined limits) of administering Resident 1's glargine insulin and should have been administered.During a concurrent interview and record review on 8/25/2025 at 12:44 p.m., with the Assistant Director of Nursing (ADON), reviewed Resident 1's MAR dated 8/2025. The ADON stated that licensed nurses should be administering medication per physicians' orders and parameters given. The ADON stated since Resident 1's blood sugar on 8/14/2025 at 9:00 p.m. was 100 mg/dL, the licensed nurse should have administered Resident 1's glargine insulin. The ADON continued to state that if Resident 1 did not receive his glargine insulin, there could be a potential for Resident 1 to experience a hyperglycemic episode. During an interview on 8/25/2025 at 4:12 p.m., with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated that LVN 2 did not administer Resident 2's glargine insulin because LVN 2 overlooked the parameters of the order. LVN 2 stated that she (LVN 2) should have read the order in its entirety. During a review of the facility's policy and procedure (P&P) titled, Administering Medications, review date 1/15/2025, the policy indicated medications are administered in a safe and timely manner, and as prescribed. The director of nursing services supervises and directs all personnel who administer without unnecessary interruptions. Medications are administered in accordance with the prescriber orders, including any required time frame.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview and record review, facility failed to ensure residents that are diabetic (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) were served sugar free gelatin and sugar free pudding for one of three sampled residents (Resident 1).This deficient practice had the potential for Resident 1 to experience hyperglycemic (occurs when glucose [sugar] levels in the blood become too high) episodes.During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 7/17/2025 with diagnoses that included cerebral infarction (stroke, loss of blood flow to a part of the brain) due to occlusion (the blockage or closing of an opening, blood vessel) or stenosis (abnormal narrowing of a blood vessel) of small artery (tiny blood vessel), type two (2) diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing) without complications, and long term use of insulin (hormone that regulate the amount of glucose in the blood).During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 8/6/2025, the MDS indicated the resident had severe cognitive (the mental process involved in knowing, learning, and understanding things) impairment. The MDS indicated Resident 1 required partial/moderate assistance from staff with eating, oral hygiene, required substantial/maximal assistance from staff personal hygiene, and is dependent on staff with toileting hygiene.During a review of Resident 1's Order Summary Report, the Order Summary Report indicated an order for consistent carbohydrate/no added salt (NAS) diet (diet consistency that helps control blood sugar levels), ordered 8/11/2025.During a review of Resident 1's care plan (a document that summarizes a resident's needs, goals, and care/treatment), initiated 8/4/2025, the care plan indicated the resident has hyperglycemia related to DM. The care plan indicated an intervention to discuss meal times, portion size, dietary restrictions, snacks allowed in daily nutritional plan, compliance with nutritional regimen and monitor compliance with diet and document any problems.During an observation on 8/25/2025 at 12:58 p.m., observed Resident 1's lunch tray with an orange gelatine cup that is unlabeled and observed a pudding cup with the letter R written on top of the pudding cup cover.During a concurrent observation and interview on 8/25/2025 at 12:59 p.m., with Licensed Vocational Nurse 1 (LVN 1), in Resident 1's room, observed Resident 1's lunch tray. LVN 1 stated that Resident 1's orange gelatine is regular gelatine and not sugar free. LVN 1 continued to state that the pudding served on Resident 1's lunch tray was regular pudding because there is an R written on the top cover of the pudding. LVN 1 stated that the orange gelatine is regular because there is no label that it is sugar free.During a concurrent observation and interview on 8/25/2025 at 1:15 p.m., with the Registered Dietician (RD), in Resident 1's room, observed Resident 1's lunch tray. The RD stated the RD was not sure if the orange gelatine was sugar free or regular because it is not labeled. The RD stated that the pudding served to Resident 1 is regular pudding because there is an R marked on the top cover. The RD stated that Resident 1's diet should be consistent carbohydrate diet and should have been served sugar free gelatine and sugar free pudding because Resident 1 is diabetic. The RD continued to state that serving residents with diabetes regular gelatine and/or regular pudding will affect the residents' blood sugar levels.During a review of the facility's policy and procedure (P&P) titled, Consistent Carbohydrate Diet, review date 1/15/2025, the policy indicated the consistent carbohydrate diet is indicated for residents with diabetes or prediabetes. It provides consistent meal patterns and portion sizes in order to assist residents in achieving blood glucose and weight goals. This diet is planned to meet the current dietary reference intakes within the limitations of the diet restrictions. Modifications of the diet may be necessary for complications of diabetes and associated diseases.

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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. Based on observation, interview, and record review, the facility failed to follow proper food handling practices by failing to ensure clear storage cups of gelatin were dated and labeled according to the facility's policy.This deficient practice had the potential to place 142 out of 148 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). During an observation of the facility's kitchen refrigerator on 8/25/2025 at 1:45 p.m., observed open food items not in its original packaging and placed in clear storage cups. Observed several clear storage cups labeled SF and several clear storage cups with no labels. During a concurrent observation and interview on 8/25/2025 at 1:46 p.m., with the Dietary Supervisor (DS), the DS stated that the clear storage cups are cups of gelatine for the residents. Observed the DS count the clear storage cups. The DS stated 35 of the clear storage cups had no label and counted 11 clear storage cups labeled SF. The DS stated that SF meant sugar free and is served to residents with consistent carbohydrate diet (diet consistency that helps control blood sugar levels). The DS stated that when a food item is not in its original packaging, the food item must be labeled with the specific name of the food item and the date when the food item was opened/prepared. When asked about the importance of accurate labeling, the DS stated that it is important to accurately label food items to make sure that the food item is what it is and for the safety of the residents. The DS further stated that the person preparing the gelatine is responsible for labeling. During a review of the facility's policy and procedure (P&P) titled, Food Safety Product Labeling & Dating Guide, review date 1/15/2025, the policy indicated under storing prepared food; Applies to: Purchased, ready-to-eat food removed from original container. Product storage label: Name of product, date of preparation and/or use-by date.