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	02/27/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. 49947 Based on observation, interview, and record review, the facility failed to: 1. Ensure residents are provided with a call light (a device used by a patient to signal his or her need for assistance from a professional staff) that the resident can use and within the resident's reach for two of three (Resident 34 and Resident 395) sampled residents reviewed under the environment task. 2. Ensure that a call light was answered by any staff member walking by the room for 1 of three sampled residents (Resident 134) reviewed in environment task. These deficient practices had the potential to result in the residents unable to call health care workers for assistance and delay in the provision of necessary care and services that can negatively affect resident's comfort and well-being. Findings: 1.a. During a review of Resident 34's Admission Record, the Admission Record indicated the facility admitted Resident 34 on 9/14/2022 with diagnoses including atherosclerotic heart disease (a condition where plaque [fats and other substances], builds up inside the arteries, causing them to narrow and potentially blocking blood flow to the heart), muscle weakness, major depressive disorder (a mental health condition that causes persistent feelings of sadness and hopelessness), and fall on same level from slipping, tripping and stumbling. During a review of Resident 34's Minimum Data Set (MDS - an assessment and care screening tool) dated 12/10/2024, the MDS indicated Resident 34 was able to understand others and make herself understood. The MDS indicated Resident 34 needed substantial assistance from staff for bathing, dressing, and toileting and moderate assistance for mobility while in bed and transfers. The MDS also indicated repeated falls. During a review of Resident 34's Self-Care Performance Deficit (less than what is needed or expected) Care Plan (CP) initiated on 1/2/2024 and last revised on 1/9/2025, the CP indicated an intervention to encourage the use of call light for assistance - ensure call light is within reach, secure to bed for easy access through the next review date of 03/12/2025. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 2/24/2025 at 9:30 am in Resident 34's room, Resident 34 was asleep, and the call light was under her mattress and not within reach. During a concurrent observation and interview on 2/24/2025 at 9:34 am with a Care Partner (a person employed by the facility to assist CNA's for resident's basic care needs) in Resident 34's room, the Care Partner confirmed Resident 34's call light was under her mattress and not within reach. The Care Partner stated the call light must always be within the resident's reach so they can call for help, especially if there is an emergency. During an interview on 2/27/2025 at 11:24 am with Registered Nurse (RN) 1, RN 1 stated the call light must be within reach so the resident can call for help and to prevent a delay in care. During a review of the facility's policy and procedure titled, Call System, Resident last reviewed on 1/15/2025, the policy indicated the facility will provide a means to call staff for assistance through a communication system that directly calls a staff member or centralized workstation. The policy indicated each resident is provided with a means to call staff directly for assistance from the bed, from toileting/bathing facilities and from the floor. 2. During a review of Resident 134's Admission Record, the Admission Record indicated the facility admitted Resident 134 on 1/18/2025 with diagnoses including history of falling, dysphagia, age related osteoporosis (a disease that causes bones to weaken and become more likely to break), paralysis of vocal cords (a condition that causes the loss of control of the muscles that control the voice) and larynx (the voice box containing vocal cords). During a review of Resident 134's History and Physical (H&P), dated 1/20/2025, the H&P indicated Resident 134 had the capacity to understand and make decisions. During a review of Resident 134's Minimum Data Set (MDS - an assessment and care screening tool) dated 12/10/2024, the MDS indicated Resident 134 was able to understand others and make herself understood. The MDS indicated Resident 134 needed moderate assistance from staff for bathing, dressing, and toileting and a history of falls. During a review of Resident 134's Self-Care Performance Deficit (less than what is needed or expected) Care Plan (CP) initiated on 1/19/2025 and last revised on 1/30/2025, the CP indicated an intervention to encourage the use of call light for assistance - ensure call light is within reach, secure to bed for easy access through the next review date of 04/25/2025. During an observation on 2/24/2025 at 10:05 am in Resident 134's room, Resident 134's was up in her bed with the call light in her hand. The call light was lit in her room and outside of her door to indicate she needed assistance. At 10:07 am, the Director of Nursing (DON) was seen walking by the room without entering or addressing the call light. Moments later, the DON is seen walking by the room again without entering or addressing the call light. During a concurrent observation and interview on 2/24/2025 at 10:08 am outside Resident 134's room with the DON, the DON confirmed the call light was on for Resident 134. The DON stated he was looking for a CNA to assist the resident but that he should have entered immediately to check on the resident first. The DON stated call lights should be answered by any staff member immediately to prevent a delay in care and accidents. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure titled, Call System, Resident last reviewed on 1/15/2025, the policy indicated the facility will provide a means to call staff for assistance through a communication system that directly calls a staff member or centralized workstation. The policy indicated calls for assistance are answered as soon as possible, but no later than five minutes. 47883 1.b. During a review of Resident 395's Admission Record, the Admission Record indicated the facility admitted the resident on 2/6/2025 with diagnoses including sepsis (a serious condition in which the body responds improperly to an infection. The infection-fighting processes turn on the body, causing the organs to work poorly), major depressive disorder (a serious mental illness that can cause a persistent low mood, loss of interest, and other symptoms that affect how a person feels, thinks, and acts), and reduced mobility. During a review of Resident 395's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 2/12/2025, the MDS indicated the resident had intact cognition (mental action or process of acquiring knowledge and understanding). The MDS indicated Resident 395 was unable to walk and was totally dependent on two-person extensive assistance for all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During a review of Resident 395 History and Physical (H&P), dated 1/20/2025, the H&P indicated Resident 395 had the capacity to understand and make decisions. During a review of Resident 395's Care Plan (a document that outlines the actions and interventions needed to address a resident's health and care needs) for ADL, the Care Plan indicated that the resident required assist of one-to-two person to start and complete most ALDs task. The care plan tasks indicated to ensure call light is within reach and ensure a call light was available to the resident, and the resident's needs were anticipated and met. During an observation on 2/24/2025 at 10:46 a.m. in Resident 395's room, observed the resident lying in bed, the call light was located under Resident 395's pillow on the left side of the bed. Resident 395 stated she could not reach the call light because of weakness in her hands and arms. Resident 395 stated that usually she called the nurse when she saw staff passing her room. During a concurrent observation and interview on 2/24/2025 at 10:50 a.m. with Licensed Vocational Nurse 3 (LVN 3) in Resident 395's room, LVN 3 concurred that the resident could not reach the call light, when the call light was located under the resident's pillow. The call light was placed in the resident's left hand, and she was asked to push the call light. The resident stated that she could not use her fingers to push the red button, and she usually pushes the red button against her chin and demonstrated how she pushed. When asked by the surveyor if this call light is appropriate for Resident 395's condition, LVN 3 stated the facility has different types of call light devices which can be used in cases when a resident cannot use a regular call light. LVN 3 stated that he will provide Resident 395 with adaptive tap call light (when resident does not need to push just lightly tap). LVN 3 stated if the resident was not able to call for assistance, they would be at risk for delayed care. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/26/2023 at 12:03 p.m., with the Director of Nursing (DON), the DON stated that Resident 395 should be provided with adaptive call button, the resident's care plan should reflect the needs of adaptive device. The DON stated the call light should be placed within reach to the resident to be able to call for assistance in case of emergency and for staff to meet their needs. During a review of the facility's policy and procedure titled, Call System, Resident last reviewed on 1/15/2025, the policy indicated the facility will provide a means to call staff for assistance through a communication system that directly calls a staff member or centralized workstation. If resident has a disability that prevents him/ her from making use of the call system, an alternative means of communication that is usable for the resident is provided and documented in care plan.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 44309 Based on interview, and record review, the facility failed to implement their policy and procedure for Advanced Directive (AD-a written instruction, recognized under State law, relating to the provision of health care when the individual is unable to make decisions for themselves) for one (1) of 13 sampled residents (Resident 11) by not obtaining a copy of the resident`s Living Will (a document that specifies a residents preferences about measures that are used to prolong life when there is a terminal prognosis) and maintain it in the resident`s medical record. This deficient practice had the potential for the facility to not honor the resident's medical decisions regarding end-of-life treatment. Findings: During a review of Resident 11's Admission Record (face sheet), the admission record indicated that the facility originally admitted the resident on 9/30/2017, and readmitted on [DATE], with diagnoses including weakness, atrial fibrillation (a condition when the heart beats irregularly and rapidly), and heart failure (a condition where the heart muscle cannot pump blood effectively enough to meet the body's needs). During a review of Resident 11's Minimum Data Set (MDS - a resident assessment tool) dated 11/28/2024, 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 intact (decisions consistent/reasonable). The MDS indicated that Resident 11 requires partial/moderate assistance (helper does less than half the effort) for toileting hygiene, showering, and bathing. During a review of Resident 11's Advance Directive Acknowledgement Form (ADA-a document provided by the facility that indicates whether a resident has an Advance Directive, would like information regarding creation of an advance directive, or refusal to create an advance directive) dated 5/28/2024, the ADA form indicated that the resident had executed a Living Will and have provided the document to the facility. During a concurrent interview and record review on 2/25/2025 at 2:21 p.m., with Social Worker 1 (SW1), Resident 11's ADA form was reviewed. SW 1 stated that Resident 11`s ADA form signed by his Responsible Party (RP) on 5/28/2024, indicated that the resident has a Living Will. SW1 stated that a copy of Resident 11`s living will should be in his medical chart. SW1 stated she did not follow up attempts with Resident 11 or his RP to ensure the facility has a copy of Resident 11`s AD in the medical chart. SW1 stated staff are required to obtain a copy of the resident`s AD and place it in medical chart in a location that it can be easily seen so that all direct care staff are aware of the resident`s wishes. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 2/26/2025 at 9:10 a.m., with the Director of Social Services (DSS), Resident 11`s ADA and social service assessments were reviewed. The DSS stated that Resident 11 ADA form signed on 5/28/2024, indicated that the resident has a living will. The DSS stated a copy of Resident 11`s AD is not available in his chart. The DSS stated if a resident has executed an Advance Directive, a copy of it should be placed in the resident's chart. The DSS stated the potential outcome of not having a copy of the resident`s AD in the medical chart 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 1/15/2025, the P&P indicated that 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 AD. If the resident or the resident`s representative has executed one or more ADs, 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 residents direct care staff and physician by placing the AD documents in a prominent, accessible location in the medical record and discussing the residents wishes in care planning meeting.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49947 Based on interview, and record review, the facility: 1. Failed to notify the resident's representative when the resident's medication Gemtesa (medication for overactive bladder [an organ that holds urine]) was no longer covered by insurance and before it ran out on 2/11/2025, for one of five sampled residents (Resident 112) reviewed under unnecessary medications. This deficient practice had the potential to negatively affect Resident 112 and their representative's right to be informed of a change in their medication. 2. Failed to notify the resident's representative of a change of condition for one of one resident (Resident 27) reviewed under Notification of Change care area when Resident 27's family member (FM 2) was not notified when Resident 27 had a diagnosis of Methicillin- Resistant Staphylococcus aureus (MRSA- type of bacteria that is resistant to the antibiotic). This deficient practice had the potential to violate Resident 27's representative the right to be informed of a change in the resident's condition. Findings: 1. During a review of Resident 112's Admission Record, the Admission Record indicated the facility admitted Resident 112 on 6/15/2023 with diagnoses including Alzheimer's Disease (progressive state of decline in mental abilities), Parkinson's Disease (a progressive neurological [relating to the brain, spinal cord, and nerves] disorder that affects movement, balance, and coordination), major depressive disorder (a mental health condition that causes persistent feelings of sadness and hopelessness), and a history of falling. During a review of Resident 112's Physician's Progress Note, dated 1/7/2025, the Physician's Progress Note indicated Resident 112 had the capacity to understand and make decision and had urinary incontinence (inability to control urine flow) with improvement in bladder spasms (sudden uncontrollable squeezing of the bladder) and urination when on Gemtesa. The progress note further indicated the resident to continue using Gemtesa. During a review of Resident 112's Minimum Data Set (MDS - an assessment and care screening tool) dated 12/18/2024, the MDS indicated Resident 112 was able to understand others and make herself understood. The MDS indicated Resident 112 needed moderate assistance on staff for bathing, dressing, and toileting. During a review of Resident 12's Physician's Orders, the order indicated Gemtesa oral tablet - give 75 milligrams (mg - a unit of measurement) by mouth one time a day for overactive bladder was discontinued on 2/19/2025. (continued on next page)

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	555822	A. Building B. Wing	02/27/2025

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 112's Bladder Incontinence (inability to control the flow of urine from the bladder) Care Plan (CP) initiated on 6/26/2023 and last revised on 7/8/2024, the CP indicated goals to keep Resident 112 clean, dry and free of odors and to reduce episodes of incontinence through the next review date of 03/18/2025. During a review of Resident 112's Electronic Medical Administration Record (EMAR - online charting system), the EMAR indicated the charting code 3 entered by the Licensed Vocational Nurses (LVN) indicates Hold/Progress Note MD Notification, The EMAR further indicated for the medication Gemtesa: - On 2/11/2025 at 9:00am a code of 3 was documented by LVN 4. During a review of Resident 112's Progress Notes for the medication Gemtesa: - On 2/11/2025 LVN 4 entered awaiting refill from RX, medicine NA. During an interview on 2/26/2025 at 11:40 am with Resident 112's family member (FM 2), FM 2 stated he was disappointed when LVN 4 told him on 2/18/2025 that Resident 112 went without Gemtesa for over 5 days. FM 2 further stated he was never told insurance did not cover the medication anymore and had he known, he would have called to get a similar medication that is covered. FM 2 stated it is unacceptable for the facility to not communicate with him. During a phone interview on 2/26/2025 at 1:47 pm with LVN 4, LVN 4 stated on 2/11/2025 the bubble pack (a card that packages doses of medication within small, clear, plastic bubbles that is punched out to administer to a resident) for Gemtesa was completely empty and indicated a 3 in the EMAR and wrote that the medication was NA (LVN 4 clarified NA meant not available) and waiting for delivery from RX (LVN 4 clarified RX meant pharmacy). LVN 4 then stated when she worked again on 2/18/2025, the bubble pack was still empty and indicated a 3 in the EMAR again, requested a refill from the pharmacy again and then spoke with Resident 112's family member to inform him that the medication has been unavailable for several days. LVN 4 stated Resident 112's family member stated he was never told in advance that the medication was out and Resident 112's family member was going to call Resident 112's pharmacy. LVN 4 stated she was unaware why other LVNs indicated they administered Gemtesa on 2/12/2025 -2/16/2025 on the EMAR when the medication was not available on 2/11/2025 and 2/18/2025. LVN 4 further stated the refill of Gemtesa should have been followed up by the other LVNs to minimize the number of days the Resident 112 went without Gemtesa. During an interview on 2/26/2025 at 2:15 pm with Registered Nurse (RN) 1, RN 1 stated medicine in bubble packs must be reordered when there are about 7 tablets left to give time for any insurance issues and for the medication to arrive before the current stock runs out. RN 1 stated Resident 112's Gemtesa should have never run out without replenishment or replacement because Resident 112's incontinence could worsen and possibly lead to skin breakdown. RN1 further explained the resident, or their representative must be informed if a medication is not available so they can participate in getting an alternate medication. During a review of the facility's policy and procedure (P&P) titled, Change in a resident's condition or status, last reviewed on 1/15/2025, the P&P indicated: our facility promptly notifies the resident, his or her attending physician, and the resident representative of change in the resident's medical /mental condition and /or status. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility provided P&P titled, Medication Administration, last reviewed 1/15/2025, the P&P indicated medication errors are documented, reported, and reviewed by the QAPI committee to inform process changes and/or the need for additional staff training. The P&P further indicted if a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall document/initial and circle the MAR space provided for that drug and dose. 47883 2. During a review of Resident 27's Admission Record, the Admission Record indicated that the facility originally admitted the resident on 12/17/2024, and readmitted on [DATE], with diagnoses including 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), type 2 diabetes (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 atrial fibrillation (a heart condition that causes an irregular and often abnormally fast heart rate). During a review of Resident 27's Minimum Data Set (MDS - a resident assessment tool) dated 1/7/2025, 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 maidly impaired (mildly impaired cognition (a slight decline in mental abilities, memory and completing complex tasks). The MDS indicated that Resident 27 was dependent on the staff (helper does all the effort) for showering/bathing and lower body dressing, and moderate- to- maximal assistance for all other of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During a review of Resident 27's Physician Orders, the Physician Orders indicated an order dated 2/21/2025, to place the resident under contact precautions related to MRSA in the urine. During an observation on 2/24/2025 at 8:48 a.m. outside Resident 27's room, observed a sign posted which indicated that Resident 27 was placed on Contact Preauction (steps taken to prevent the spread of infections that can be passed by touching an infected person or contaminated surfaces) and required the wearing of Personal Protective Equipment (PPE) before entering the resident's room. During a phone interview on 2/24/2025 at 2:31 p.m. with Resident 27's family member (FM 3), FM 3 stated that she was not notified about Resident 27 developing MRSA. FM 3 stated that she was notified by staff about Resident 27 developing a urinary tract infection (UTI- an infection in any part of the urinary system) and a room change that was unaware about Resident 27 having MRSA. FM 3 stated no one notified her when Resident 27 was diagnosed with MRSA. During a concurrent record review and interview on 2/26/2025 at 11:39 a.m. with Licensed Vocational Nurse 2 (LVN 2), LVN 2 reviewed Resident 27's nursing progress notes, dated 2/20/2025, which indicated Resident 27 's FM was notified of Resident 27's being seen by an MD with new orders being received. LVN 2 stated that he did not notify FM 3 that Resident 27 was diagnosed with MRSA. During an interview on 2/26/2025 at 12:15 p.m. with Social Worker 2 (SW 2), SW 2 stated that she called Resident 27's FM on 2/21/2025 to notify them about Resident 27's room change. SW 2 stated that she did not mention anything about Resident 27's diagnosis of MRSA. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent record review and interview on 2/26/2025 at 12:46 p.m. with Licensed Vocational Nurse 1 (LVN 1), reviewed Resident 27's Change of Condition Report (COC) dated 02/21/2025. The COC indicated that Resident 27 was noted with decline in oral intake, was recently diagnosed with MRSA in urine, and was on oral antibiotics. LVN 1 stated that she notified MD and family member about the decline in oral intake but did not notify FM 2 about Resident 27's diagnosis of MRSA. LVN 1 stated it is important to notify FM 3 about the resident's change of condition, so that FM 3 can understand the disease process and participate in Resident 27's care planning. During an interview on 2/27/2025 at 11:35 a.m. with the Infection Preventionist (IP), the IP stated that Resident 27's FM should be notified by licensed nurses about the change of condition including the diagnosis of MRSA so that FM 3 can understand and participate in Resident 27's care planning. The IP stated that not notifying FM 3 about Resident 27's infection may increase the potential of the spread of infection in the facility. During an interview on 2/27/2025 at 12:03 PM with the Director of Nursing (DON), the DON stated that Resident 27's FM should have been notified about the resident's the MRSA diagnosis. The potential outcome of not notifying FM 3 about the resident's the MRSA diagnosis is the spread of infection in the facility. During a review of the facility's policy and procedure (P&P) titled, Change in a resident's condition or status, last reviewed on 1/15/2025, the P&P indicated: our facility promptly notifies the resident, his or her attending physician, and the resident representative of change in the resident's medical /mental condition and /or status.

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	555822	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47883 Based on interview and record review, the facility failed to ensure the Minimum Data Set (MDS - a standardized assessment and screening tool) was transmitted timely to the Centers for Medicare and Medicaid Services (CMS) system for one (1) out of one (1) sampled residents (Resident 30). This deficient practice had the potential to result in delayed services to Resident 30. Findings: During a review of the Admission Record, the Admission Record indicated Resident 30 was admitted to the facility on [DATE] with diagnosis including periprosthetic fracture around internal prosthetic left knee (a type of fracture that occurs in the bone surrounding a knee replacement implant), osteoarthritis (a condition where the protective cartilage in the joints wear down over time, causing pain, stiffness, and swelling), and diabetes type 2 (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). During a review of the physician order dated 11/3/2024, the physician order indicated an order to discharge Resident 30 on 11/3/2024 to a board and care facility with Home Health Care (HHC). During a review of the Minimum Data Set assessment dated [DATE], (MDS, a standardized assessment and care screening tool), the MDS indicated Resident 30 had mildly impaired cognition (a slight decline in mental abilities, memory and completing complex tasks). The MDS indicated Resident 30 required moderate assistance for all activities of daily living (ADL- basic tasks that must be accomplished every day for an individual to thrive). During a concurrent interview and record review on 2/27/2025 at 2:45 p.m., with Minimum Data Set Coordinator 1 (MDSC 1), Resident 30`s MDS assessments were reviewed. The MDSC 1 stated it is required to complete a MDS assessment when a resident is being discharged from the facility. MDSC 1 stated, We have 14 days to complete the discharge MDS. MDSC 1 stated Resident 30 was discharged from the facility on 11/3/2024, however the MDS for discharge was not completed and not submitted to Center for Medicaid Services (CMS). During an interview on 2/27/2025 at 3:15 p.m., with Director of Nursing (DON). The DON stated the discharge assessment has to be done by the MDSC and submitted to CMS in 14 days. The DON stated the potential outcome of not completing discharge the MDS assessment on time is a delay in care and payment for Resident 30. During a review of the facility's Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, Version 1.19.1 dated October 2024, indicated all Medicare and/or Medicaid-certified nursing homes and swing beds, or agents of those facilities, must transmit required MDS data records to CMS' Internet Quality Improvement and Evaluation System (iQIES). Comprehensive assessments must be transmitted electronically within 14 days of the Care Plan Completion Date. All other MDS assessments must be submitted within 14 days of the MDS completion date.

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	555822	A. Building B. Wing	02/27/2025

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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** 44309 Based on interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan (a plan of care that summarizes a resident's health conditions, specific care and services facility staff need to provide a resident to promote healing and prevent a worsening of a condition, and current treatments) to meet the resident`s needs for two of three sampled residents (Resident 345 and Resident 27) by failing to:  1. Develop and implement a comprehensive person-centered care plan addressing Resident 345`s oxygen use. This deficient practice had the potential to result in Resident 345`s inadequate care.  2. Develop and implement a comprehensive person-centered care plan addressing Resident 27`s antibiotic (medications that are used to treat infection by stopping bacteria from reproducing or destroying them) use. This deficient practice had the potential to increase Resident 27 's risk for adverse effects of antibiotics. Findings: 1. During review of Resident 345`s Admission Record (face sheet), the Admission Record indicated that the facility originally admitted the resident on 12/1/2023, and readmitted on [DATE], with diagnoses including chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), and acute (short term) respiratory failure (when not enough oxygen passes from your lungs to your blood) with hypoxia (a medical condition that occurs when there is an inadequate supply of oxygen to the body's tissues). During a review of Resident 345's Minimum Data Set (MDS-a resident assessment tool) dated 2/18/2025, 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 345 required partial/moderate assistance (helper does less than half effort) for upper body dressing, and personal hygiene. The MDS further indicated that Resident 345 was receiving intermittent (on and off) oxygen therapy upon admission and while a resident inside the facility. During a review of Resident 345's Order Summary Report (physician order) dated 2/11/2025, the order summary report indicated to administer oxygen at two (2) liters per minute via nasal canula (NC- a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) as needed for hypoxia/shortness of breath. The order summary report indicated to change the oxygen tubing (including NC, mask, and storage bag) every week and as needed and date the tubing and storage bag. During a review of Resident 345's care plans, the care plans did not indicate a documented evidence of a comprehensive care plan addressing Resident 345`s oxygen use. (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 concurrent interview and record review on 2/25/2025 at 2:00 p.m., with Registered Nurse 1 (RN 1), Resident 345`s physician orders and care plans were reviewed. RN 1 stated that Resident 345`s is using oxygen, however, licensed staff did not develop a comprehensive care plan with person-centered interventions for the resident`s oxygen use. RN 1 stated there should have been a care plan developed with person-centered goals and interventions to monitor Resident 345`s oxygen use. RN 1 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 the resident requires. During an interview on 2/27/2025 at 2:09 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 345`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 1/15/2025, 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. 47883 2. During a review of Resident 27's Admission Record, the Admission Record indicated that the facility originally admitted the resident on 12/17/2024, and readmitted on [DATE], with diagnoses including 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), type 2 diabetes (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 atrial fibrillation (a heart condition that causes an irregular and often abnormally fast heart rate). During a review of Resident 27's MDS dated [DATE], 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 maidly impaired (mildly impaired cognition (a slight decline in mental abilities, memory and completing complex tasks). The MDS indicated that Resident 27 was dependent on the staff (helper does all the effort) for showering/bathing and lower body dressing, and moderate- to- maximal assistance for all other of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During a review of Resident 27's Physician Orders, the Physician Orders indicated an order dated 2/21/2025 for Zyvox (antibiotic used to treat bacterial infection) oral tablet 600 milligrams (mg- unit of measurement), give 1 tablet by mouth two times a day for diagnosis of Methicillin- Resistant Staphylococcus aureus (MRSA- type of bacteria that is resistant to the antibiotic) in urine for 7 days. (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 Resident 27's Physician Orders indicated, the Physician Orders indicated an order dated 2/21/2025 for Doxycycline (antibiotic used to treat infection) tablet 100 mg, give 1 tablet by mouth every 12 hours for MRSA in urine for 5 days. During a review of Resident 27's Physician Orders, the Physician Orders indicated an order dated 2/23/2025 for Vancomycin (antibiotic used to treat infection) intravenous solution 500 mg /100 milliliters (ml-unit of measurements), use 1 gram intravenously one time only for urinary tract infection (UTI- an infection in any part of the urinary system) for one day. During a review of Resident 27's Physician Orders, the Physician Orders indicated an order dated 2/24/2025 for Ceftazidime (antibiotic used to treat bacterial infection) intravenous solution 2 gram intravenously every 8 hours for UTI for 5 days. During a concurrent interview and record review on 2/26/ 2025 at 9:57 a.m. with Minimum Data Set Coordinator 2 (MDSC 2), MDSC 2 reviewed Resident 27 's care plans (a document that outlines a patient's health information, conditions, treatments, care services, and goals) for antibiotic use for UTI and stated that she did not find any care plans reflecting that Resident 27 was receiving the following antibiotics: Zyvox, Doxycycline, Vancomycin and Ceftazidime. During an interview and concurrent record review with the Director of Nursing (DON) on 2/27/2024 at 12:03 p. m., the DON stated that the facility missed initiating a care plan addressing Resident 27's antibiotic administration. The DON stated that a care plan on antibiotic administration is important because the care plan should provide specific interventions regarding these medications. During a review of the facility's policy and procedure titled, Comprehensive Person-Centered Care Plans, last reviewed 1/15/2025, the policy and procedure indicated the following: -The IDT, in conjunction with the resident and his/her family develops and implements a comprehensive, person-centered care plan for each resident -The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. -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.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34659 Based on observation, interview, and record review, the facility failed to revise a resident's care plan to reflect the use of floor or landing mats (a cushioning pad placed by a resident's bed to absorb the force of a resident falling) for a resident who was at high risk for falls for one out of three sampled residents (Resident 1) investigated for accidents and hazards. This deficient practice had the potential to increase the resident's risk for injury in the event of a fall. Findings: During a review of Resident 1's Admission Record (front page of the chart that contains a summary of basic information about the resident), the Admission Record indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including fall and neuropathy (disease or dysfunction of one or more nerves, typically causing numbness, weakness, or pain in the hands and feet). During a review of Resident 1' s Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 1/15/2025, the MDS indicated Resident 1 had a fall since the last MDS assessment. During a review of Resident 1's MDS, dated [DATE], the MDS indicated Resident 1 was severely 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 Resident 1 was dependent (helper does all of the effort) on staff for upper and lower body dressing and putting on or taking off footwear. During a review of Resident 1's Fall Risk Evaluation, dated 2/03/2025, the evaluation indicated the resident was at high risk for falls. During a review of Resident 1's Care Plan (CP) for Falls Risk, initiated 2/03/2025, the CP indicated a goal that Resident 1 will be free of significant injury secondary to falls through the review date. One of the interventions, added 2/24/2025, indicated a floor/landing pad to be placed next to bed bilaterally (on both sides). During an observation and interview with Resident 1 and Certified Nursing Assistant 3 (CNA 3) on 2/24/2025 at 2:45 p.m., observed Resident 1 in their bed. Resident 1 stated he had a floor mat that was on his right side but is now placed on the left side. CNA 3 stated they use only one landing mat on the floor for Resident 1. During an interview with Licensed Vocational Nurse 6 (LVN 6) on 2/24/2025 at 3:03 p.m., they stated it is usually just one landing mat in Resident 1's room for that resident. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review with the Assistant Director of Nursing (ADON) on 2/24/2025 at 3:44 p.m., reviewed Resident 1's Post Fall Accident Assessment, dated 12/17/2024. The ADON stated Resident 1 does not currently have an order for any landing mat but will follow up and, if indicated, Resident 1 would most likely need a landing mat on each side since Resident 1 fell on the left side when they attempted to get from their wheelchair to bed without assistance. The ADON stated for Resident 1 staff would not know which side Resident 1 would fall on which is why two landing mats are needed. During a concurrent interview and record review with the Director of Nursing (DON) on 2/26/2025 at 4:29 p.m. , reviewed the facility's policy and procedure titled, Fall Prevention - Potential Interventions, last reviewed 1/15/2025. The policy indicated fall reduction methods included placing a mattress placed on the floor. The DON stated this intervention includes the use of floor/landing mats placed next to residents' beds. The DON stated the process is for the Interdisciplinary Team (IDT, a group of health professionals from different disciplines who work together to treat a resident) accesses for a need for one or two landing mats for a resident to prevent falls. The DON stated the IDT should have assessed the resident for landing mats before the one landing mat was placed. The DON stated after assessment, where there is a new intervention, it should be added to the care plan. The DON stated Resident 1 needed two landing mats because they had a fall from wheelchair to the floor on the left side on 12/16/2025. The DON stated Resident 1 might attempt to get out of bed on either side so two landing mats are needed. The DON stated the importance of having the landing mats is to prevent any injuries if the resident has a fall. The DON confirmed that the intervention for bilateral floor/landing pad was added to the Falls Risk Care Plan after being brought to attention by the survey team on 2/24/2025. During a review of the facility's policy and procedure titled, Comprehensive Person-Centered Care Plans, last reviewed 1/15/2025, indicated the following: -The IDT, in conjunction with the resident and his/her family develops and implements a comprehensive, person-centered care plan for each resident -The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. -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.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 49947 Based on interview and record review the facility failed to ensure residents receive treatment and care in accordance with professional standards of practice by failing to rotate (a method to ensure repeated injections are not administered in the same area) subcutaneous (beneath the skin) insulin (a hormone that lowers the level of glucose [a type of sugar] in the blood) injection sites to two of two sampled residents (Resident 76 and Resident 111) reviewed under the insulin care area. The deficient practice had the potential for adverse effect (unwanted, unintended result) of same site subcutaneous administration of insulin such as lipodystrophy (abnormal distribution of fat), bruising and pain. Cross reference F760 Findings: a. During a review of Resident 76's Admission Record, the Admission Record indicated the facility admitted Resident 76 on 10/20/2023 with diagnoses that included, but not limited to type 2 diabetes mellitus (a disease that occurs when the glucose, also called blood sugar, is too high), neuropathy (damage, disease, or dysfunction of one or more nerves) and major depressive disorder (a mental health condition that causes persistent feelings of sadness and hopelessness). During a review of Resident 76's History and Physical (H&P), dated 10/25/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 76's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 4/3/2024, the MDS indicated the resident had some impaired cognition, needed maximal assistance from staff for activities such as toileting, dressing, bathing and personal hygiene, and was on a high-risk drug class medication hypoglycemic (a group of drugs used to help reduce the amount of sugar present in the blood). During a review of Resident 76's Order Summary Report, the report indicated an order dated 9/12/2024, Insulin Glargine subcutaneous (SQ - in the fatty layer of the skin) Solution 100 units per milliliters (unit/ml, a unit of fluid volume) inject 12 units SQ at bedtime. During a review of Resident 76's 2/2025 Medication Administration Record (MAR) reviewed on 2/27/2025 at 10:30am, the MAR indicated the insulin was administered on the following dates and sites: Insulin Glargine SQ 100 unit/ml subcutaneous solution: 2/1/2025 - abdomen - left upper quadrant (LUQ) 2/2/2025 - abdomen - left upper quadrant (LUQ) 2/3/2025 - abdomen - left upper quadrant (LUQ) (continued on next page)

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	555822	A. Building B. Wing	02/27/2025

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2/4/2025 - abdomen - left upper quadrant (LUQ) 2/5/2025 - abdomen - left upper quadrant (LUQ) 2/6/2025 - abdomen - left upper quadrant (LUQ) 2/7/2025 - abdomen - left upper quadrant (LUQ) 2/9/2025 - abdomen - left upper quadrant (LUQ) 2/10/2025 - abdomen - left upper quadrant (LUQ) 2/11/2025 - abdomen - left upper quadrant (LUQ) 2/12/2025 - abdomen - left upper quadrant (LUQ) 2/13/2025 - abdomen - left upper quadrant (LUQ) 2/16/2025 - abdomen - left upper quadrant (LUQ) 2/17/2025 - abdomen - left upper quadrant (LUQ) 2/18/2025 - abdomen - left upper quadrant (LUQ) 2/19/2025 - abdomen - left upper quadrant (LUQ) During a concurrent interview and record review on 02/27/25 at 11:27 am with Registered Nurse 1 (RN 1), reviewed Resident 76's MAR. RN 1 stated there were multiple instances where the injection sites of insulin were not rotated in 2/2025. RN 1 stated the licensed nurses must follow the instructions in the manufacturer's guidelines and rotate sites of insulin administration to prevent damage to the skin tissues of the resident and medication error. During a review of the facility's recent policy and procedure titled, Adverse Consequences and Medication Errors, last reviewed on 1/15/2025, indicated a medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer's specifications, or accepted professional standards and principles of the professional(s) providing services. During a review of the facility's recent policy and procedure titled, Insulin Administration, last reviewed on 1/15/2025, indicated injection sites should be rotated, preferably within the same general area (abdomen, thigh, upper arm). During a review of the facility provided medication insert instructions for Insulin Glargine, undated, the insert indicated to change (rotate) injection sites within the area chosen for each dose to reduce the risk of getting lipodystrophy (pits in the skin or thickened skin) and localized cutaneous amyloidosis (skin with lumps) at the injection sites. (continued on next page)

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	555822	A. Building B. Wing	02/27/2025

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. During a review of Resident 111's Admission Record, the Admission Record indicated the facility admitted Resident 111 on 10/11/2024 with diagnoses that included, but not limited to type 2 diabetes mellitus (a disease that occurs when the glucose, also called blood sugar, is too high), and major depressive disorder (a mental health condition that causes persistent feelings of sadness and hopelessness). During a review of Resident 111's History and Physical (H&P), dated 1/9/2025, the H&P indicated the resident did have the capacity to understand and make decisions. During a review of Resident 111's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 12/27/2024, the MDS indicated the resident had the capacity to make herself understood and understand others, needed moderate assistance from staff for activities such as toileting, dressing, bathing and personal hygiene, and was on a high-risk drug class medication hypoglycemic (a group of drugs used to help reduce the amount of sugar present in the blood). During a review of Resident 111's Order Summary Report, the report indicated an order dated 11/30/2024 for Humulin R Injection Solution 100 u/ml. Inject as per sliding scale (sliding scale, increasing administration of the pre-meal insulin dose based on the blood sugar level before the meal) before meals and at bedtime. During a review of Resident 111's 12/2024 Medication Administration Record (MAR), the MAR indicated Humulin R Injection Solution 100 unit/ml subcutaneous solution was administered on the following dates and sites: 12/2/2024 -11:30 am - abdomen - left lower quadrant (LLQ) 12/2/2024 - 9:00 pm - abdomen - left lower quadrant (LLQ) 12/3/2024 - 9:00 pm - abdomen - left lower quadrant (LLQ) 12/12/2024 - 11:30 am - abdomen - left lower quadrant (LLQ) 12/12/2024 - 4:30 pm - abdomen - left lower quadrant (LLQ) During a concurrent interview and record review on 02/27/25 at 11:30 am with Registered Nurse 1 (RN 1), reviewed Resident 111's MAR. RN 1 stated there were multiple instances where the injection sites of insulin were not rotated in 12/2024. RN 1 stated the sites of insulin administration should be rotated to prevent damage to the skin tissues of the resident. During a review of the facility's recent policy and procedure titled, Adverse Consequences and Medication Errors, last reviewed on 1/15/2025, the policy and procedure indicated a medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer's specifications, or accepted professional standards and principles of the professional(s) providing services. During a review of the facility's recent policy and procedure titled, Insulin Administration, last reviewed on 1/15/2025, the policy and procedure indicated injection sites should be rotated, preferably within the same general area (abdomen, thigh, upper arm). (continued on next page)

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	555822	A. Building B. Wing	02/27/2025

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility provided medication insert instructions for Humulin R, undated, the insert indicated to rotate injection sites to reduce risk of lipodystrophy and localized cutaneous amyloidosis.

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	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canyon Oaks Nursing and Rehabilitation Center	22029 Saticoy Street Canoga Park, CA 91303

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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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38469 Based on observation, interview and record review, the facility failed to provide appropriate treatment and services to maintain or improve the resident's ability to carry out the activities of daily living for one (Resident 48) of two residents investigated under vision and hearing by failing to ensure Resident 48's hearing aid was functioning to allow the resident to better hear and improve her ability to communicate. This deficient practice had the potential to prevent the resident from communicating with staff and had the potential for the delay of providing the resident the necessary care, treatment or services. Findings: During a review of Resident 48's Admission Record, the Admission Record indicated that the facility originally admitted the resident on 03/29/2020 and readmitted on [DATE], with diagnoses including muscle weakness and hearing loss. During a review of Resident 48`s Minimum Data Set (MDS - a standardized assessment and care screening tool) dated 12/16/2024, the MDS indicated that Resident 48 had the ability to usually makes self-understood and had the ability to understand others. The MDS indicated Resident 48 is using a hearing aid. The MDS indicated that the resident required maximal assistance with toileting hygiene, shower, upper body dressing, putting on and taking off footwear and personal hygiene. During an observation and concurrent interview on 02/25/2025 at 8:58 a.m., Resident 48 was in her bed awake and when spoken to, Resident 48 stated she cannot hear, and her hearing aid is broken. During an interview and record review on 02/26/25 at 8:25 a.m., with the Assistant Director of Nursing (ADON), reviewed Resident 48`s MDS Section B dated 12/16/2025. The the MDS Section B indicated that Resident 48 can hear adequately with a hearing aid.  During an observation and interview on 02/26/2025 at 8:35 a.m., with Resident 48 in the presence of the ADON in Resident 48`s room, observed the ADON asked Resident 48 whether her hearing aid is working. Resident 48 repeatedly stated that she cannot hear, and her hearing aid is not working. During an interview on 02/26/2025 at 8:40 a.m., with Certified Nurse Assistant 1 (CNA1) in Resident 48`s room and in the presence of the ADON. CNA1 stated she does not now when Resident 48's hearing aid stopped working. (continued on next page)

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	555822	A. Building B. Wing	02/27/2025

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow-up interview on 02/26/2025 at 08:45 a.m., with the ADON, the ADON stated that hearing aids helps resident communicate their needs to the caregivers. The ADON stated that it would be frustrating to not be able to hear and understand when conversing with the staff. The ADON stated that the resident`s needs will not be met if her ability to communicate is impaired due to the malfunctioning hearing aid. The ADON stated that the CNA should have reported the broken hearing aid so that Social Services Department can address the issue. The ADON stated there is nothing in the notes of the Social Services Department pertaining to the broken hearing aid. During a review of the facility`s policy and procedures titled Hearing Aid, Care of, last reviewed on 1/15/2025, indicated that The purpose of this procedure is to maintain the resident`s hearing at the highest attainable level .notify the supervisor if hearing aid is damaged or needs to be sent to the dealer for cleaning .

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38469 Based on interview and record review, the facility failed to ensure one of three residents (Resident 98) reviewed under the Activities care area was provided activities according to his/her activity preferences. This deficient practice violated the resident`s right to have access and receive activity services important to the resident which had the potential to affect the resident`s sense of self-esteem and self-worth. Findings: During a review of Resident 98's Admission Record, the Admission Record indicated that the resident was originally admitted on [DATE] and readmitted to the facility on [DATE], with diagnoses that included but not limited to, hepatomegaly (an enlarged liver) and benign prostatic hyperplasia (a condition in which the prostate gland, located below the bladder in men, enlarges). During a review of Resident 98`s Admission Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 01/30/2025, the MDS indicated the resident`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 and required maximal assistance from staff for oral hygiene, toileting hygiene, shower, dressing. The MDS also indicated in Section F that it is important to the resident to go outside to get fresh air when the weather is good. During an interview and record review on 02/26/2025 at 10:03 a.m., with the Activity Director (AD), reviewed Resident 98`s Activity Participation (AP) attendance for the month of January and February 2025 and Section F of the MDS, dated [DATE]. The AD stated that Resident 98 had not been provided outdoor activity for the past two months as reflected in the AP. The AD stated that they should have provided the resident`s preferred activity of wanting to be out in the sun to enjoy the weather. The AD stated that having an outdoor activities is physically beneficial and good for the resident`s well-being.  During a review of the facility`s policy and procedure titled Activity Programs, last reviewed on 01/15/2025, the policy and procedure indicated that Activity programs are designed to meet the interests of and support the physical, mental and psychosocial well-being of each resident .activities offered are based on the comprehensive resident-centered assessment and the preferences of each resident .

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	555822	A. Building B. Wing	02/27/2025

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38469 Based on interview and record review the facility failed to ensure the resident received care consistent with professional standards of practice to promote healing, prevent infection and prevent new pressure ulcers (injuries to the skin and underlying tissue resulting from prolonged pressure) from developing by failing to notify the physician prior to the treatment stop date that the treatment needed to continue, as the resident's pressure ulcer had not fully healed for one of one resident (Resident 98) reviewed under the Pressure Ulcer/Injury care area. This deficient practice had the potential for worsening of the pressure ulcer. Findings: During a review of Resident 98's Admission Record, the Admission Record indicated that the resident was originally admitted on [DATE] and readmitted to the facility on [DATE], with diagnoses that included but not limited to, hepatomegaly (an enlarged liver), benign prostatic hyperplasia (a condition in which the prostate gland, located below the bladder in men, enlarges) and pressure ulcer Stage 2 (when the wound extends into the bottom layers of the skin) of sacral region (located at the lower end of the spine, below the lumbar vertebrae and above tailbone). During a review of Resident 98`s Admission Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 01/30/2025, the MDS indicated the resident`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 and required maximal assistance from staff for oral hygiene, toileting hygiene, shower, dressing. During a review of the Skin and Wound Evaluation on 01/20/2025, the evaluation indicated that Resident 98 was admitted with stage 2 pressure ulcer to the sacral region measuring 0.9 centimeter (cm) in length and 0. 9 cm in width. During a review of Resident 98`s Physician`s Order dated 01/21/2025, the Physician Order indicated an order to cleanse sacrum with normal saline, pat dry, apply zinc oxide and cover with dry dressing every day shift for pressure injury for 21 days (21st day is 02/10/2025). During a review of Resident 98`s Treatment Administration Record (TAR) for the month of February 2025, the TAR indicated that the last day of the treatment to the pressure ulcer in the sacral region was on 02/10/2025 (21st day). The TAR indicated that the same treatment was resumed on 02/20/2025 until 02/26/2025. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and record review on 02/26/2025 at 11:22 a.m., with Treatment Nurse 1 (TN1), reviewed Resident 98`s Physician`s Order dated 01/21/2025 (cleanse sacrum with normal saline, pat dry, apply zinc oxide and cover with dry dressing every day shift for pressure injury for 21 days) and TAR for the month of February 2025. TN 1 stated that the treatment to the stage 2 pressure ulcer in the sacral region ended on 02/10/2025 and no treatment was provided from 02/11/2025 to 02/19/2025. TN 1 stated that the same treatment was resumed on 02/20/2025 and ended on 02/26/2025. TN 1 stated that she did not inform the physician one day prior (2/10/2025) to the stop date of the treatment that the pressure ulcer has not resolved or fully healed. TN 1 stated that the wound could have worsen and could have resulted to infection when no treatment was provided from 02/11/2025 to 02/19/2025. TN 1 stated she overlooked and failed to notify the physician and obtain an order to continue the treatment. During a review of the facility`s policy and procedure titled Medication and Treatment Orders, last reviewed on 01/15/2025, indicated that Orders for medications and treatments will be consistent with principles of safe and effective order writing .one day prior to the date the stop order is to become effective, the nurse supervisor/charge nurse on duty must contact the prescriber or attending physician to determine if the medication/treatment is to be continued .

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	555822	A. Building B. Wing	02/27/2025

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34659 Based on observation, interview, and record review, the facility failed to: 1. Ensure a resident, who was assessed as unsafe to self-administer medications, was not left unattended with a Diclofenac Gel 1% (also known as Voltaren, a medication applied to the skin to reduce pain by reducing inflammation [swelling]) at the bedside one of one sampled resident (Resident 1). This deficient practice had the potential for other residents to enter the room and take the medication or for Resident 1 to apply too much of the medication too often. 2. Ensure a resident who was at high risk for falls had floor mats (a cushioning pad placed by a resident's bed to absorb the force of a resident falling) as ordered by the physician for one out of three sampled residents (Resident 1) investigated for accidents and hazards. Findings: 1. During a review of Resident 1's Face sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including neuropathy (disease or dysfunction of one or more nerves, typically causing numbness, weakness, or pain in the hands and feet). During a review of Resident 1's Census List (a list of a resident's admissions, room changes, discharges to the hospital, and re-admissions) indicated Resident 1 was transferred to a General Acute Care Hospital (GACH, or simply hospital) 1/15/2025 and readmitted to the facility on [DATE]. During a review of Resident 1's MDS, dated [DATE], the MDS indicated Resident 1 was severely 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 Resident 1 was dependent (helper does all of the effort) on staff for upper and lower body dressing and putting on or taking off footwear. During a review of Resident 1's Physician's Orders, the Physician Ordered indicated the following orders: -Voltaren, apply to affected area topically every eight hours as needed for pain management, dated 10/05/2023. (The order was discontinued when Resident 1 was discharged to the GACH on 1/15/2025.) -Voltaren, apply to affected area topically every eight hours as needed for pain management, dated 1/29/2025. During an observation and interview with Resident 1 on 2/24/2025 at 2:45 p.m., observed Resident 1 in his bed. Resident 1 stated he had pain 8/10 to his knees. Resident 1 stated he rubs the Diclofenac gel cream on his knees that was on his bedside table. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation, record review, and concurrent interview with Licensed Vocational Nurse 6 (LVN 6) on 2/24/2025 at 3:03 p.m., observed the medication cart in which Resident 1's medications are located. LVN 6 was unable to locate Resident 1's Voltaren in the medication cart. LVN 6 reviewed Resident 1's Physician's orders which indicated there was an order dated 1/29/2025 for Voltaren. During an interview with the Treatment Nurse 1 (TN 1) on 2/24/2025 at 3:30 p.m., TN 1 stated TN 1 searched the treatment cart and Resident 1's Voltaren was not there. TN 1 stated they were unfamiliar with Resident 1's medication because it was not on Resident 1's Treatment Administration Record (TAR - a daily documentation record used by a licensed nurse to document treatments given to a resident). During an observation on 2/24/2025 at 3:40 p.m., observed TN 1 rubbing the Voltaren gel on Resident 1's knees. During a review of Resident 1's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), the MAR indicated TN 1 applied the Voltaren to Resident 1's knees on 2/24/2025 at 3:47 p.m. During an interview with the Assistant Director of Nursing (ADON) on 2/24/2025 at 3:44 p.m., the ADON stated Resident 1 told them that their family member brought Voltaren to the resident. The ADON stated it is important to keep Voltaren in the medication cart so the licensed nurses can monitor the resident's pain and because other residents could take it. During an interview with the ADON on 2/25/2025 at 9:38 a.m., the ADON stated if Resident 1 was assessed by the interdisciplinary team (IDT, a group of health care professionals with various areas of expertise who work together toward the resident's goals) as being able to self-administer the Voltaren then the licensed nurses would complete an assessment indicating Resident 1 could self-administer the Voltaren, and they would also obtain a physician's order to self-administer the medication. The ADON stated there was no assessment indicating it was safe for Resident 1 to self-administer the Voltaren and there was no order for Resident 1 to self-administer the Voltaren. During a concurrent interview with the Director of Nurses (DON) on 2/26/2025 at 4:29 p.m., the DON stated if a resident's IDT assessed a resident as able to self-administer medications, then the licensed nurses will obtain a physician's order, self-administration assessment would be completed, and the medication(s) would be kept locked in the resident's bedside draw with the resident only having the key. During a phone interview with Resident 1's Family Member 1 (FM 1), on 2/27/2025 at 10:57 a.m., FM 1 stated he brought the Voltaren gel for Resident 1 that was on his bedside table. FM 1 stated Resident 1 needed the medication for pain relief. During a review of the facility's policy and procedure titled, Self-Administration of Medications, last reviewed 1/15/2025, indicated the following: As part of the evaluation comprehensive assessment, the IDT assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident. The IDT considers: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The medication is appropriate for self-administration; -The resident is able to read and understand medication labels; -The resident can follow directions and tell time to know when to take the medication; -The resident comprehends the medication's purpose, proper dosage, timing, signs of side effects and when to report these to the staff; 2. During a review of Resident 1's Fall Risk Evaluation, dated 1/29/2025, the evaluation indicated the resident was at high risk for falls. During a review of Resident 1's Care Plan (CP) for Falls Risk, initiated 2/03/2025, the CP indicated a goal that Resident 1 will be free of significant injury secondary to falls through the review date. One of the interventions, added 2/24/2025, indicated floor/landing pad to be placed next to bed bilaterally (on both sides). During an observation and interview with Resident 1 and Certified Nursing Assistant 3 (CNA 3) on 2/24/2025 at 2:45 p.m., observed Resident 1 in his bed. Resident 1 stated he had a floor mat that was on his right side but is now placed on the left side. CNA 3 stated they use only one landing mat on the floor for Resident 1. During an interview with Licensed Vocational Nurse 6 (LVN 6) on 2/24/2025 at 3:03 p.m., LVN 6 stated it is usually just one landing mat in Resident 1's room for that resident. During a concurrent interview and record review with the Assistant Director of Nursing (ADON) on 2/24/2025 at 3:44 p.m., reviewed Resident 1's Post Fall Accident Assessment, dated 12/17/2024. The ADON stated Resident 1 does not currently have an order for any landing mat but will follow up and stated Resident 1 would probably need a landing mat on each side since Resident 1 fell on the left side when they were trying to get from their wheelchair to bed without assistance. The ADON stated for Resident 1 staff would not know which side Resident 1 would fall on which is why two landing mats are needed. During a concurrent interview and record review with the Director of Nursing (DON) on 2/26/2025 at 4:29 p.m. , reviewed the facility's policy and procedure titled, Fall Prevention - Potential Interventions, last reviewed 1/15/2025. The policy indicated fall reduction methods included placing a mattress placed on the floor. The DON stated this intervention includes the use of floor/landing mats placed next to residents' beds. The DON stated the licensed nurses access for a need for one or two landing mats for a resident to prevent falls. The DON stated Resident 1 needed two landing mats because they had a fall from wheelchair to the floor on the left side on 12/16/2025. The DON stated Resident 1 might attempt to get out of bed on either side so two landing mats are needed. The DON stated the importance of having the landing mats is to prevent any injuries if the resident has a fall. The DON confirmed that the intervention for bilateral floor/landing pad was added to the Falls Risk Care Plan after being brought to attention by the survey team on 2/24/2025.

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	555822	A. Building B. Wing	02/27/2025

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47883 Based on interview and record review the facility failed to ensure that residents who needed respiratory care (the health care discipline that specializes in the promotion of optimum cardiopulmonary function and health and wellness) were provided such care, consistent with professional standards of practice to one out of two sampled residents (Resident 136) by failing to administer oxygen (a colorless, odorless, and tasteless gas, that supports life) to Resident 136 as per the physician's order. These deficient practices had the potential to negatively impact Resident 136's respiratory well-being. Findings: During a review of Resident 136's Admission Record, the Admission Record indicated that the facility initially admitted Resident 136 on 1/20/2025 with diagnoses including respiratory failure (a condition in which your blood does not have enough oxygen causing shortness of breath and difficulty breathing, often caused by a disease or injury) with hypoxia (low levels of oxygen in the body tissues), heart failure (when heart muscle cannot pump enough blood to meet the body's needs), and parkinsonism (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination). During a review of Resident 136's History and Physical (H&P), dated 1/21/2025, the document indicated that the resident had the capacity to understand and make decisions. During a review of Resident 136's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 1/26/2025, the MDS indicated that the resident had mildly impaired cognition (a slight decline in mental abilities, memory and completing complex tasks). The MDS further indicated that Resident 136 needed supervision for eating, maximal assistance for upper body dressing, oral and personal hygiene, and was dependent on assistance of two or more helpers for showering, toileting hygiene, lower body dressing and bed-chair transfer. During a review of Resident 136's Physician Order, dated 1/21/2025, the Physician Order indicated an order for oxygen at two (2) liters/minute (l/min- unit of measurement for oxygen flow) via nasal cannula (a device that gives additional oxygen through the nose) as needed (PRN- when required), for hypoxia (low levels of oxygen in the body tissues) or shortness of breath. The goal is to maintain oxygen saturation (a percentage of oxygen-saturated hemoglobin [a protein in red blood cells that carries oxygen from lungs to the body's tissues and organs] in the blood compared to total hemoglobin) above 90%. During the review of Resident 136's Medication Administration Record (MAR), the vital signs dated 2/25/2025, the MAR indicated that the resident's oxygen saturation was 90%. (continued on next page)

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	555822	A. Building B. Wing	02/27/2025

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 2/24/2024 at 9:24 AM in Resident 136's room with Registered Nurse 2 (RN 2), Resident 136 was observed in his bed sleeping with the nasal canula not connected to the resident and instead under Resident 136's gown. The oxygen concentrator was on at two liters of flow. RN 2 stated that oxygen had to be administered to Resident 136 via nasal canula at 2 l/min to keep oxygen saturation over 90%. RN 2 connected the oxygen to Resident 136 via nasal canula at 2 l/min. RN 2 stated that Resident 136 required oxygen because of his hypoxia and the location of nasal canula under the resident's gown may lead to cross contamination (the act of making something unclean or harmful). During an interview on 2/27/2024 at 12:03PM with the Director of Nursing (DON), the DON stated that oxygen should be administered to Resident 136 according to the physician's order to prevent the possibility of worsening of Resident 136's respiratory illness. During a review the facility Policy and Procedure named Oxygen Administration, last reviewed on 1/15/2025, the document indicated to remove any [NAME] blanket, nylon and/or [NAME] clothing, etc , from immediate area where oxygen is to be administered .Place appropriate oxygen device on resident (mask, nasal canula/or nasal catheter). Before administering oxygen, and while the resident is receiving oxygen, assess the following .securely anchor the tubing that it does not rub or irritate the resident's nose, behind the resident's ears.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 44309 Based on interview, and record reviews, the facility failed to follow their policy and procedure for pain assessment and management for one of one sampled resident (Resident 38) reviewed under pain by failing to: 1. Conduct pain assessments after Resident 38`s change of conditions (a deviation from a resident`s normal state of health that can be physical, mental, or behavioral) on 12/8/2024 and 2/13/2025. 2. Thoroughly complete Resident 38`s Pain Risk Evaluation form on 12/30/2024.  3. Monitor Resident 38 for presence of pain on 2/7/2025 and 2/23/2025.  These deficient practices had the potential to negatively affect Resident 38`s psychosocial well-being and quality of life. Findings: During a review of Resident 38's Admission Record (face sheet), the admission record indicated that the facility admitted the resident on 8/27/2024, with diagnoses including secondary malignant neoplasm of bone (a cancerous tumor in bone which expands quickly and can spread to other areas of the body), secondary malignant neoplasm of peritoneum (a thin, smooth membrane that lines the abdominal cavity and covers most of the abdominal organs) and retroperitoneum (an anatomical space located behind the abdominal or peritoneal cavity), and gout (a form of inflammatory arthritis that causes pain and swelling in your joints). During a review of Resident 38's Minimum Data Set (MDS-a resident assessment tool) dated 12/30/2024, 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 intact (decisions consistent/reasonable). The MDS indicated that Resident 38 was dependent to staff (helper does all of the effort) for toileting hygiene, showering/bathing, lower body dressing, and putting on/taking off footwear. The MDS indicated that Resident 38 received scheduled and PRN (as needed) pain medications in the last five days. The MDS further indicated that Resident 38 has almost constantly experienced pain or hurting (pain that is present most of the time) over the last five days. During a review of Resident 38`s Order Summary Report (physician orders) dated 11/16/2024, the Order Summary Report indicated to monitor the resident for presence of pain during every shift including verbal/non-verbal pain (expression of pain through physical behaviors and facial expressions, rather than using words) using pain scale of 0-10 (pain rating scale of zero being no pain and 10 being the worst pain possible) 0=no pain, 1-2=least pain, 3-4=mild pain, 5-6=moderate pain, 7-8=severe pain, 9-10=very severe/worst pain. (continued on next page)

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	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canyon Oaks Nursing and Rehabilitation Center	22029 Saticoy Street Canoga Park, CA 91303

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 38`s SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents) Communication Form dated 12/8/2024, the SBAR communication form indicated that the resident had left shoulder pain that was radiating to his arm. The SBAR communication form indicated that although Resident 38 had pain but was able to move his left arm. During a review of Resident 38`s care plan (a document outlining a detailed approach to care customized to an individual resident's need) titled Resident is Receiving Pain Medication, initiated on 12/11/2024, the care plan indicated a goal that the resident will not have an interruption in normal activities due to pain through the review date. The care plan interventions were to monitor for presence of pain during every shift, provide non-pharmacological pain interventions (treatments that reduce pain without using medication) during every shift, administer analgesia medications (a drug that treats pain) as ordered by the physician, and evaluate the effectiveness of pain interventions during every shift and PRN. During a review of Resident 38`s Pain Risk Evaluation form dated 12/30/2024, the pain risk evaluation form indicated that the resident did not verbalize any symptoms of pain. The pain risk evaluation form did not indicate the names of both scheduled and PRN medications used for Resident 38.  During a review of Resident 38`s SBAR Communication Form dated 2/13/2025, the SBAR communication form indicated that the resident had new or worsening pain. The SBAR communication form indicated that Resident 38 was experiencing pain in the upper left area of his ribs. During a review of Resident 38's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for 2/1/2025-2/26/2025, the MAR indicated no entries for the resident`s pain monitoring on 2/7/2025 and 2/23/2025 during the evening shift.  During a concurrent interview and record review on 2/26/2025 at 3:34 p.m., with Registered Nurse 1 (RN1), Resident 38`s SBARs, pain risk evaluations and MAR for February were reviewed. RN1 stated Resident 38 had a change of condition on 12/8/2024 for new onset of pain to his left shoulder. RN 1 stated on 2/13/2025, Resident 38 had a change of condition for pain in the upper left area of his ribs. RN 1 stated licensed staff did not develop and complete pain risk evaluations after Resident 38`s change of conditions on 12/8/2024 and 2/13/2025. RN 1 stated licensed staff are required to complete a pain risk evaluation upon resident`s admission to the facility, quarterly, and whenever there is a significant change in the resident condition. RN 1 stated the potential outcome of not completing a pain risk evaluation is the inability to assess resident`s pain and implement proper interventions to relieve the pain. RN 1 stated licensed staff did not complete Resident 38`s pain risk evaluation thoroughly on 12/30/2024. RN 1 stated the pain risk evaluation form did not indicate the names of both scheduled and PRN medications used for Resident 38. RN1 stated that a residents` assessments for pain must be complete and include all pertinent information regarding the resident. RN 1 stated Resident 38`s MAR for February did not indicate any entries for the resident`s pain monitoring on 2/7/2025 and 2/23/2025 during the evening shift. RN 1 stated licensed nurses did not document that they monitored Resident 38`s pain on 2/7/2025 and 2/23/2025. RN 1 stated staff are required to monitor Resident 38`s pain during every shift as ordered by his physician. RN 1 stated the potential outcome of not monitoring a resident`s pain is worsening of the pain and the inability to implement timely interventions to control the pain. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility`s Policy and Procedures (P&P) titled Pain Assessment and Management, last reviewed on 1/15/2025, the P&P indicated that comprehensive pain assessments are conducted upon admission to the facility, at the quarterly review, whenever there is a significant change in condition, and when there is onset of new pain or worsening of existing pain. Assess the resident at admission, and during ongoing assessments to help identify the resident who is experiencing pain or for whom pain may be anticipated during specific procedures, care, or treatment. Monitor the resident for the presence of pain and the need for further assessment when there is a change of condition. Monitor the resident`s pain and consequences of pain at least each shift for acute pain or significant changes in levels of chronic pain and at least weekly in stable chronic pain.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38469 Based on interview and record review the facility failed to complete the Hemodialysis (HD, the removing of waste and excess fluid to prevent build up in the body for residents who have loss of kidney [organs that remove waste products from the blood and produce urine] function) Communication Record with information including post dialysis assessment of the access site (locations on the body where a needle or catheter can be inserted to provide access to the bloodstream for hemodialysis treatment) and post dialysis vital signs for one of one resident (R108) investigated under the dialysis care area. This deficient practice placed the resident at risk for delayed detection of potential complications after dialysis treatment such as blood clot formation and bleeding which could lead to hemorrhage. Findings: During a review of Resident 108's Admission Record, the Admission record indicated that the resident was admitted on [DATE], with diagnoses including history of falling and end stage renal disease (a severe medical condition where the kidneys have permanently lost their ability to function adequately). During a review of Resident 108`s Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 01/14/2025, the MDS indicated the resident`s cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was impaired and required assistance from staff for toileting, shower, dressing and personal hygiene. During a review of Resident 108's Order Summary Report dated 03/30/2023, the Order Summary Report indicated an order for dialysis treatment every Tuesday-Thursday-Saturday at 09:30 a.m. for 4 hours. During an interview and record review on 02/26/25 at 11: 15 a.m., with the Assistant Director of Nursing (ADON), reviewed Resident 108`s Dialysis Unit/SNF Communication Record dated 01/25/2025 and 01/30/2025. The Dialysis Unit/SNF Communication Record form indicated that post dialysis vital signs must be obtained, and access site assessment will be documented if the following signs and symptoms of dialysis complications are observed, namely: a. Redness b. Swelling c. Drainage d. Prolonged bleeding; (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Dialysis Unit/SNF Communication Record on these dates (1/25/25 and 1/30/25), indicated that post dialysis vital signs and access site assessment were not done. The ADON stated that it is important to assess the access site for any complications and obtain the resident's vital signs after a dialysis treatment. The ADON stated that if the resident is not assessed then it can result to undetected complications which could worsen and result to negative outcome such as bleeding and hemorrhage. During a review of the facility policy and procedure titled, End-Stage Renal Disease, Care of a Resident with, last reviewed on 1/15/2025, the policy and procedure indicated that Residents with end-stage renal disease will be cared for according to currently recognized standards of care .including resident receiving dialysis care outside the facility . the nature and clinical management of ESRD (including infection prevention and nutritional needs) .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 43455 Based on observation, interview, and record review the facility failed to: 1. Replace one open used medication emergency kit ([ekit]-storage container for emergency use medications) within 72 hours of opening the kit on 2/13/2025, in one (1) of two (2) inspected medication rooms (Medication Room Station 2.) 2. Account for one (1) dose of Controlled Medication (also known as Controlled Drug and Controlled Substance [CM, CD, CS]- medications which have a potential for abuse and may also lead to physical or psychological dependence) for Resident 25 in one (1) of four (4) inspected medication carts (Station 2 Medication Cart 1.) 3. Reconcile (the process of comparing transactions and activity to supporting documentation) two (2) medication ekit containing CMs for February 2025, in one (1) of four (4) inspected medication carts (Station 1 Medication Cart 2.) As a result, control and accountability of CM and availability of medications did not follow state and federal regulations and facility policy and procedures. These deficient practices increased the opportunity for CM diversion (the transfer of a controlled medication or other medication from a lawful to an unlawful channel of distribution or use,) and the risk that residents in the facility could have accidental exposure to harmful medications and delayed medication treatment during emergencies possibly leading to physical and psychosocial harm, and hospitalization . 4. Provide routine drug Gemtesa (medication for overactive bladder [a organ that holds urine]) from 2/11/2025 to 2/19/2025 to one of three sampled residents reviewed under the unnecessary medication task. This deficient practice resulted in the resident not receiving their prescribed medication. 5. Ensure a resident's pro re nata (prn, medication as needed) pain relief medication was available to a resident after being ordered for a resident for one of 33 random sampled residents (Resident 1). This had the potential for Resident 1 to not receive pain relief. Findings: 1.During an observation on 2/24/2025 at 1:14 p.m., with Registered Nurse (RN) 1, in Medication Room Station 2, there was: -One (1) open medication ekit labeled B002 with a document indicating the ekit was opened on 2/13/2025 at 12:45 p.m. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview, RN 1 stated the medication ekit labeled B002 was opened on 2/13/2025, used and awaiting replacement for a new one from pharmacy. RN 1 stated the mediation ekit should have been replaced with a new one from pharmacy within 24 hours of opening the kit. RN 1 stated the medication ekit was not replaced with a new one within 24 hours and this failure could lead to negative consequence for residents by not having emergency medications readily available during emergency situations causing resident harm and potential hospitalization . 2. During an observation on 2/25/2025 at 11:07 a.m., with Licensed Vocational Nurse (LVN) 4, in Station 2 Medication Cart 1, there was a discrepancy in the count between the Controlled Drug Record accountability log and the amount of medication remaining in the medication bubble pack (medication packaging system that contains individual doses of medication per bubble) for the following residents: -One dose of pregabalin (a CM used for neuropathy [nerve damage or disease that can cause pain, numbness, tingling, or weakness]) 50 milligram ([mg] - a unit of measure of mass) tablet was missing from the medication bubble pack compared to the count indicated on the Controlled Drug Record accountability log for Resident 445. The Controlled Drug Record accountability log for pregabalin indicated the medication bubble pack should have contained a total of 48 pregabalin 50 mg tablets, after the last administration of pregabalin 50 mg tablet documented/signed-off on 2/24/2025 at 5 p.m., however the medication bubble pack contained 47 pregabalin 50 mg tablets and no other documentation of subsequent administrations. During a concurrent interview, LVN 4 stated LVN 4 administered pregabalin 50 mg tablet to Resident 445 that morning at 9 a.m. and forgot to sign the Controlled Drug Record accountability logs. LVN 4 stated LVN 4 failed to follow the facility's policy of signing each CM dose on the Controlled Drug Record accountability log after preparing the dose for the resident. LVN 4 stated LVN 4 understood it was important to sign each dose once administered to ensure accountability, prevention of CM diversion, and accidental exposures of harmful substances to residents. LVN 4 stated if documentation was not accurate then it can lead to medication error if overdosed (administering more than the prescribed dose) leading to stoppage of breathing, hospitalization and possibly death for Resident 445. 3 During an observation on 2/25/2025 at 12:23 p.m., with LVN 3, in Station 1 Medication Cart 2 there were: -Two (2) medication ekits containing CMs without an accountability log for the reconciliation of CM inventory at every shift change for February 2025. During a concurrent interview, LVN stated that all CMs, including medication ekits containing CMs should be reconciled at every shift. LVN 3 stated that both ekits containing CMs in Station 1 Medication Cart 2 were not reconciled at every shift in February 2025, and it was important to account for all CMs to ensure accountability, prevent CM diversion and accidental exposure of harmful substances to residents. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/26/2025 at 11:34 a.m., with the Director of Nursing (DON,) in the presence of Clinical Nurse Consultant 1 (NC 1), the DON stated that open and used medication ekits should be replaced with a new one within 72 hours. The DON stated the medication ekit in Medication Room Station 2 was open and used on 2/13/2025 and not replaced within 72 hours. The DON stated this failure can create potential harm for residents by not having critical medication readily available during emergency situations. During the same interview, the DON stated that medication ekits containing CMs needed to be counted and reconciled at every shift change to ensure accountability and prevent CM diversion. The DON stated the two (2) eKits containing CMs in Station 1 Medication Cart 2 were not reconciled at each shift change for February 2025. The DON stated that the facility will immediately implement an accountability log for reconciliation of eKits at each shift change in Station 1 Medication Cart 2. During the same interview, the DON stated that LVN 4 failed to follow facility policy of documenting the preparation of CM immediately on the Controlled Drug Record accountability log for Resident 445. The DON stated not documenting the Controlled Drug Record timely can lead to accountability failures, CM diversion, inaccurate clinical records, and accidental use and overdose of harmful substances for residents. During a review of Resident 445's Admission Record (a document containing demographic and diagnostic information,) dated 2/25/2025, the Admission Record indicated Resident 445 was originally admitted to the facility on [DATE] with a diagnosis including polyneuropathy (a condition where many nerves malfunction in the body.) During a review of Resident 445's Order Summary Report, dated 2/25/2025, the report indicated Resident 445 was prescribed pregabalin 50 mg to give by mouth twice a day for neuropathy, starting 2/18/2025. During a review of Resident 445's (Medication Administration Record ([MAR] - a record of mediations administered to residents), for February 2025, the MAR indicated Resident 445 was prescribed pregabalin 50 mg twice a day for neuropathy to be given at 9 a.m. and 5 p.m., and was administered a dose on 2/25/2025 at 9 a.m. During a review of the policy and procedures (P&P), titled Emergency Medications, last reviewed 1/15/2025, the P&P indicated: The facility shall maintain a supply of medications typically used in emergencies. 2. The emergency medication kit will include medications and biologicals that are essential in providing emergency treatment. 7. Drugs from the emergency kit must be replaced within 72 hours. During a review of the P&P titled Controlled Medication Storage, last reviewed 1/15/2025, the P&P indicated that At each shift change, a physical inventory of all Schedule II ., is conducted by 2 licensed nurses .and is documented on the CS accountability record (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the P&P titled Controlled Substances, last reviewed 1/15/2025, the P&P indicated that CM are subject to special handling, storage, disposal, and recordkeeping at the nursing care center, in accordance with federal and state laws and regulations. 1. The DON and the CP establish a system of records . of all CDs .to enable an accurate reconciliation and determine that drug records are in order and that an account of all CDs is maintained and periodically reconciled. 2. When a controlled mediation is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record when removing dose from controlled storage: a. Date and time of administration b. Amount administered c. Signature of the nurse administering the dose. 6. At each shift change, a physical inventory of all CMs ., is conducted by 2 licensed clinicians and is documented on an audit record. 49947 4. During a review of Resident 112's Admission Record, the Admission Record indicated the facility admitted Resident 112 on 6/15/2023 with diagnoses including Alzheimer's Disease (progressive state of decline in mental abilities), Parkinson's Disease (a progressive neurological [relating to the brain, spinal cord, and nerves] disorder that affects movement, balance, and coordination), major depressive disorder (a mental health condition that causes persistent feelings of sadness and hopelessness), and a history of falling. During a review of Resident 112's Physician's Progress Note, dated 1/7/2025, the Physician's Progress Note indicated Resident 112 had the capacity to understand and make decision and had urinary incontinence (inability to control urine flow) with improvement in bladder spasms (sudden uncontrollable squeezing of the bladder) and urination when on Gemtesa. The progress note further indicated the resident will continue using Gemtesa. During a review of Resident 112's Minimum Data Set (MDS - an assessment and care screening tool) dated 12/18/2024, the MDS indicated Resident 112 was able to understand others and make herself understood. The MDS indicated Resident 112 needed moderate assistance on staff for bathing, dressing, and toileting. During a review of Resident 112's Bladder Incontinence (inability to control the flow of urine from the bladder) Care Plan (CP) initiated on 6/26/2023 and last revised on 7/8/2024, the CP indicated goals to keep Resident 112 clean, dry and free of odors and to reduce episodes of incontinence through the next review date of 03/18/2025. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 112's Physician's Orders, the order indicated Gemtesa oral tablet - give 75 milligrams (mg - a unit of measurement) by mouth one time a day for overactive bladder was discontinued on 2/19/2025. During a review of Resident 112's Electronic Medical Administration Record (EMAR - online charting system), the EMAR indicated the charting code 3 entered by the Licensed Vocational Nurses (LVN) indicates Hold/Progress Note MD Notification, and a check mark indicates Administered. The EMAR further indicated the following entries for the medication Gemtesa: - On 2/11/2025 at 9:00am a code of 3 by LVN 4. - On 2/12/2025 at 9:00am a check mark by LVN 9. - On 2/13/2025 at 9:00am a check mark by LVN 8. - On 2/14/2025 at 9:00am a check mark by LVN 8. - On 2/15/2025 at 9:00am a check mark by LVN 9. - On 2/16/2025 at 9:00am a check mark by LVN 9. - On 2/17/2025 at 9:00am a code of 3 by LVN 6. - On 2/18/2025 at 9:00am a code of 3 by LVN 4. - On 2/19/2025 at 9:00am a code of 3 by LVN 6. During a review of Resident 112's Progress Notes for the medication Gemtesa: - On 2/11/2025 LVN 4 documented awaiting refill from RX, medicine NA. - On 2/17/2025 LVN 6 documented medication unavailable. MD notified. - On 2/17/2025 LVN 4 documented medicine NA, awaiting refill from RX. - On 2/17/2025 LVN 6 documented medication unavailable. MD notified. During a concurrent interview and record review on 2/26/2025 at 10:20 am with LVN 8, reviewed Resident 112's EMAR. LVN 8 confirmed she worked on 2/13/2025 to 2/14/2025 and the medication Gemtesa was not available but accidently check marked in the EMAR that Gemtesa was given. LVN 8 indicated it is extremely important to be careful and accurate when charting in the EMAR so other nurses would know the medication was not available. LVN 8 further stated Resident 112 should not have gone several days without Gemtesa because it could have made her incontinence worse. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 2/26/2025 at 11:00 am with LVN 9, reviewed Resident 112's EMAR. LVN 9 confirmed she worked on 2/12/2025, 2/15/2025 and 2/16/2025 and the medication Gemtesa was not available on those days but does not remember why Gemtesa was checked off as given. LVN 9 confirmed the check marks were mistakes. LVN 9 stated the EMAR is a legal document and it is very important to be accurate when charting so other nurses know if the resident received the medication or not. During a phone interview on 2/26/2025 at 1:47 pm with LVN 4, LVN 4 stated on 2/11/2025 the bubble pack (a card that packages doses of medication within small, clear, plastic bubbles that is punched out to administer to a resident) for Gemtesa was completely empty and indicated a 3 in the EMAR and wrote that the medication was NA (LVN 4 clarified NA meant not available) and waiting for delivery from RX (LVN 4 clarified RX meant pharmacy). LVN 4 then stated when she worked again on 2/18/2025, the bubble pack was still empty and indicated a 3 in the EMAR again, requested a refill from the pharmacy again and then spoke with Resident 112's family member (FM 2) to inform him that the medication has been unavailable for several days. LVN 4 stated she was unaware why other LVNs indicated they administered Gemtesa on 2/12/2025 -2/16/2025 on the EMAR when the medication was not available on 2/11/2025 and 2/18/2025. LVN 4 further stated the Gemtesa should have been followed up by the other LVNs to minimize the number of days the Resident 112 went without Gemtesa. During an interview on 2/26/2025 at 2:15 pm with Registered Nurse (RN) 1, RN 1 stated medicine in bubble packs must be reordered when there are about 7 tablets left to give time for any insurance issues and for the medication to arrive before the current stock runs out. RN 1 further stated Resident 112's Gemtesa should have never run out without replenishment or replacement because Resident 112's incontinence could worsen and possibly lead to skin breakdown. During a review of the facility provided Policy and Procedure (P&P) titled, Charting and Documentation, last reviewed 1/15/2025, the P&P indicated the documentation in the medical record will be objective, complete and accurate. During a review of the facility provided P&P titled, Medication Administration, last reviewed 1/15/2025, the P&P indicated medication errors are documented, reported, and reviewed by the QAPI committee to inform process changes and/or the need for additional staff training. The P&P further indicted if a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall document/initial and circle the MAR space provided for that drug and dose. 34659 5. During a review of Resident 1's Admission Record, the Admission Record indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included neuropathy (disease or dysfunction of one or more nerves, typically causing numbness, weakness, or pain in the hands and feet). During a review of Resident 1's Census List (a list of a resident's admissions, room changes, discharges to the hospital, and re-admissions) indicated Resident 1 was transferred to a General Acute Care Hospital (GACH, or simply hospital) 1/15/2025 and readmitted to the facility on [DATE]. (continued on next page)

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	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 1's MDS, dated [DATE], the MDS indicated Resident 1 was severely 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 Resident 1 was dependent (helper does all of the effort) on staff for upper and lower body dressing and putting on or taking off footwear. During a review of Resident 1's Physician's Orders, the Physician's Orders indicated the following orders: -Voltaren 1% Gel, apply to affected area topically every eight hours as needed for pain management, dated 10/05/2023. (The order was discontinued when Resident 1 was discharged to the GACH on 1/15/2025). -Voltaren 1% Gel, apply to affected area topically every eight hours as needed for pain management, dated 1/29/2025. During an observation and interview with Resident 1 on 2/24/2025 at 2:45 p.m., observed Resident 1 in their bed. Resident 1 stated he had pain 8/10 to his knees. Resident 1 stated he applies the Voltaren gel cream located on his bedside table on his knees. Resident 1 stated it was brought by Family Member 1 (FM 1). During an observation, record review, and concurrent interview with Licensed Vocational Nurse 6 (LVN 6) on 2/24/2025 at 3:03 p.m., observed the Station Three Medication Cart in which Resident 1's medications are located. LVN 6 was unable to locate Resident 1's Voltaren in the medication cart. LVN 6 reviewed Resident 1's Physician's orders which indicated there was an order dated 1/29/2025 for Voltaren. LVN 6 stated he would ask the Treatment Nurse 1 (TN 1) to see if she had Resident 1's Voltaren in the treatment cart. During an interview with the TN 1 on 2/24/2025 at 3:30 p.m., they said they searched their treatment cart and Resident 1's Voltaren was not there. The TN 1 stated they were unfamiliar Resident 1 received the medication because it was not on Resident 1's Treatment Administration Record (TAR - a daily documentation record used by a licensed nurse to document treatments given to a resident). During an observation on 2/24/2025 at 3:40 p.m., observed TN 1 rubbing the Voltaren 1% gel (brought by FM 1, according to the resident) on Resident 1's knees. During a review of Resident 1's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), the MAR indicated TN 1 applied Voltaren to Resident 1's knees on 2/24/2025 at 3:47 p.m. During an interview with the Assistant Director of Nursing (ADON) on 2/24/2025 at 3:44 p.m., the ADON stated Resident 1 told them that their family member brought Voltaren to the resident. The ADON stated, when family members of a resident bring medications from home, they are to give the medication to the licensed nurses to keep in the medication cart if the medication is unable to be ordered from the pharmacy. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the ADON on 2/25/2025 at 9:38 a.m., the ADON stated the pharmacy sent a form for licensed staff to fill out asking if they wanted the medication to be sent as house supply (medication that is shared by other residents such for such commonly used medications such as Tylenol) or billed to the resident. The ADON stated the facility probably did not receive the form because it was not sent back to the pharmacy by the licensed nurses, and thus the medication was not sent to the facility from the pharmacy. During a concurrent interview with the Director of Nurses (DON) on 2/26/2025 at 4:29 p.m., the DON stated it is important for the licensed nurses to follow up with the facility's pharmacy to ensure they are available for the resident. The DON stated Resident 1 could potentially not receive pain relief by not having the medication available. The DON stated the facility did not have a specific policy for the licensed nurses to follow to ensure ordered medications were available for residents. The DON stated is important for licensed nurses to follow up with the facility's pharmacy if they do not see a resident's ordered medication in the medication cart. The DON stated they would send a copy of the in-service that will be conducted for all licensed nurses. During a phone interview with Resident 1's Family Member 1 (FM 1), on 2/27/2025 at 10:57 a.m., FM 1 stated he brought the Voltaren gel for Resident 1 that was on his bedside table. FM 1 stated Resident 1 needed the medication for pain relief. During an observation with Licensed Vocational Nurse 7 (LVN 7) on 2/27/2025 at 1:30 p.m., observed the Station Three Medication Cart. Resident 1's Voltaren gel was inside the medication cart. Voltaren's label indicated the medication was sent to the facility on [DATE] and the date opened was 2/25/2025. During a review of the facility's policy and procedure titled, Medications Brought to the Facility by the Resident/Family, last reviewed 1/15/2025, indicated residents and families must report to the nursing staff any medications that they want to bring, or have brought into the facility. During a review of the facility's in-service, titled, Medication and Treatment Orders, the document indicated the in-service was conducted 9/26/2024. The DON indicated in an email, sent 3/04/2025 indicated the following lesson plan: Steps in ordering medication: 1.) Obtain MD order 2.) Fax order to pharmacy 3.) Follow-up call with pharmacy if they received the fax 4.) Endorse to next shift if medication s/medications are not available.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38469 Based on interview and record review, the facility failed to ensure the Consultant Pharmacist`s (CP) recommendation for 12/2024 Medication Regimen Review (MRR, a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication) to give Ferrous Sulfate (iron supplement) was discussed with the physician and acted upon for one of eight (Resident 48) sampled residents. This deficient practice has placed the resident at an increased risk for untreated anemia (a condition in which the blood doesn't have enough healthy red blood cells and hemoglobin, a protein found in red blood cells, to carry oxygen all through the body) which could result to complications such as fatigue, weakness, and shortness of breath. Findings: During a review of Resident 48's Admission Record, the Admission Record indicated that the facility originally admitted the resident on 03/29/2020 and readmitted on [DATE], with diagnoses including anemia, muscle weakness and hearing loss. During a review of Resident 48`s Minimum Data Set (MDS - a standardized assessment and care screening tool) dated 12/16/2024, the MDS indicated that Resident 48 had the ability to usually makes self-understood and had the ability to understand others. The MDS indicated that the resident required maximal assistance with toileting hygiene, shower, upper body dressing, putting on and taking off footwear and personal hygiene. During an interview and record review on 02/25/2025 at 8:56 a.m., with the Assistant Director of Nursing (ADON), reviewed the Consultant Pharmacist`s Medication Regimen Review (CPMRR) created between 12/01/2024 and 12/17/2024. The review indicated that the consultant pharmacist recommended to give Ferrous Sulfate (iron supplement) 325 milligram (mg) three times a day to stimulate erythropoiesis (the production of red blood cells). The ADON stated that iron supplement is beneficial for residents` who have diagnoses of anemia. The ADON stated that anemia symptoms can include generalized weakness and makes the resident susceptible to infection. The ADON stated that the Quality Assurance Nurse (QAN)is in-charge of following up with the physician regarding consultant pharmacist`s recommendation. During an interview and record review on 2/25/25 at 4:23 p.m., with the QAN, reviewed the consultant pharmacist`s MRR created between 12/01/2024 and 12/17/2024. The QAN stated that if the consultant pharmacist has a recommendation, she will communicate the recommendation to the physician and if the physician agrees, the medication will be ordered. The QAN stated that the recommendation created between 12/01/2024 to 12/17/2024 was not discussed with the physician as there is no documentation that it was acted upon or if the physician's disagreed with the recommendation. The QAN stated that if the consultant pharmacist's recommendation was not communicated to the physician, Resident 48 could potentially experience weakness and fatigue, and her anemia will not be treated. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility`s policy and procedures titled Medication Regimen Reviews, last reviewed on 01/15/2025, indicated that The Consultant Pharmacist reviews the medication regimen of each resident at least monthly .the goal of the MRR is to promote positive outcomes while minimizing adverse consequences and potential risks associated with medication .

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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** 43455 Based on interview and record review, the facility failed to ensure that resident's drug regimen was free from unnecessary medications (any medication in excessive dose, excessive duration, without adequate monitoring) by failing to discontinue an antipsychotic [drug that affects brain activities associated with mental processes and behavior] medication for one (1) of one (1) sampled residents (Resident 76) reviewed for unnecessary medication care area. As a result, Resident 76 continued to receive aripiprazole (an antipsychotic medication used for schizophrenia [a mental disorder involving thought, emotion and behavior,]) between 1/24/2025 and 2/18/2025 without documentation indicating to do so. This deficient practice increased the risk that Residents 76 may have experienced serious adverse effects (unwanted, uncomfortable, or dangerous effects that a drug may have) of antipsychotic medication therapy, such as tardive dyskinesia (uncontrolled face muscle movements,) akathisia (inability to hold still,) tremors, dizziness, and sedation leading to an overall negative impact on their physical, mental, and psychosocial well-being. Findings: During a review of Resident 76's Admission Record (a document containing demographic and diagnostic information) dated 2/26/2025, the record indicated Resident 76 was originally admitted to the facility on [DATE] and readmitted on [DATE] with a diagnosis including schizophrenia and depression. During a review of Resident 76's Order Summary Report, dated 2/25/2025, the report indicated Resident 76 was prescribed aripiprazole 5 milligram ([mg] - unit of measure of mass) to give 0.5 tablet by mouth once a day for schizophrenia as evidenced by yelling and screaming leading to shortness of breath give half tab = 2. 5 mg, starting 6/19/2024. During a review of medication order note for Resident 76 by Psychiatric Mental Health Nurse Practitioner (PMHNP), dated 1/24/2025, the order indicated to discontinue Abilify (brand name medication for aripiprazole) 2.5 mg tablet by mouth daily for schizophrenia manifested by striking out. The order also indicated to discontinue Abilify due to stability of psychosis symptoms, patient agrees, gradual dose reductions ([GDR] - an effort to reduce or discontinue a drug) at this time, and supporting therapy provided and case discussed with staff. During a review of Resident 76's Minimum Data Set ([MDS] - a comprehensive resident assessment tool), dated 2/4/2025, the MDS indicated resident was moderately impaired with cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 76 had no mood and no behavioral symptoms, such as screaming at others. MDS indicated schizophrenia diagnosis. The MDS indicated Resident 76 received antipsychotics on a routine basis. The MDS indicated GDR was attempted on 2/2/2025 and that the GDR was not documented by a physician as clinically (relating to medical science and examination of patients) contraindicated (something that is not recommended or advised because it may be harmful.) (continued on next page)

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	555822	A. Building B. Wing	02/27/2025

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of medication order note for Resident 76 by PMHNP, dated 2/7/2025, the note indicated no apparent distress after discontinuing Abilify previous visit. During a review of Resident 76's (Medication Administration Record ([MAR] - a record of mediations administered to residents), for February 2025, the MAR indicated Resident 76 was prescribed aripiprazole 5 mg to give 0.5 tablet by mouth once a day for schizophrenia as evidenced by yelling and screaming leading to shortness of breath give half tab = 2.5 mg, to be given at 9 a.m., and Resident 76 was administered a dose every day at 9 a.m. between 2/1/2025 and 2/18/2025. During a concurrent document review and interview on 2/26/2025 at 10:42 a.m., with the Director of Nursing (DON,) the DON reviewed Resident 76's MDS dated [DATE], PMHNP orders dated 1/24/2025 and 2/7/2025 and February 2025 MAR. The DON stated PMHNP order on 1/24/2025 indicated to discontinue Resident 76's Abilify 2.5 mg order, and PMHNP note on 2/7/2025 indicated PMHNP believed Resident 76 was no longer receiving Abilify. The DON stated Resident 76 did not have any behaviors of screaming documented on the MDS, aligning with PMHNP orders to attempt GDR by discontinuing Abilify. The DON stated the February 2025 MAR indicated aripiprazole 2.5 mg was not discontinued and Resident 76 continued to receive aripiprazole until 2/18/2025 without documentation indicating to do so. The DON stated the facility failed to discontinue aripiprazole as per physician orders and document clinical rationale to continue aripiprazole, placing Resident 76 at risk of receiving unnecessary psychotropic medications which could result in adverse consequences and side effects, negatively impacting the resident's health and well-being. The DON stated the DON will contact PMHNP and obtain orders as applicable. During a review of the facility's policy and procedures (P&P), titled Psychotropic Medication Use, last reviewed 1/15/2025, the P&P indicated: 1. A psychotropic medication is any medication that affects brain activities associated with mental processed and behavior. 2. Drugs in the following categories are considered psychotropic drugs medications and are subject to prescribing, monitoring and review requirements specific to psychotropic medications: a. Antipsychotics 9. Consideration of the use of psychotropic medication is based on comprehensive review of the resident. 11. Residents on psychotropic medications receive GDR, unless clinically contraindicated in an effort to discontinue these medications. During a review of the facility's policy and procedures (P&P), titled Tapering Medications and Gradual Drug Dose Reduction, last reviewed 1/15/2025, the P&P indicated: 1. After medications are ordered for a resident, the staff and practitioner shall seek an appropriate dose and duration for each medication that also minimizes the risk of adverse consequences. 2. All medications shall be considered for possible tapering. Tapering that is applicable to psychotropic medications are referred to as GDR. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Residents who use psychotropic medications shall receive GDR and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. 4. The staff and practitioner will consider tapering .when: a. The resident's clinical condition has improved or stabilized. 6. The physician will order appropriate tapering of medications, as indicated.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 43455 Based on observation, interview and record review, the facility failed to ensure that medication error rate was less than five percent (%). Six medication errors out of 25 total opportunities contributed to an overall medication error rate of 24% for one of four residents (Resident 95) observed during medication administration. Resident 95 received six medications in a form that was not ordered by Resident 95's physician. The deficient practice of medication administration without the physician's orders increased the risk for Resident 95 to experience medication adverse reactions (unwanted, uncomfortable, or dangerous effects that a medication may have) and potential complications. Findings: During concurrent observation and interview on 2/24/2025 at 9:12 am in medication cart 1, with Licensed Vocational Nurse (LVN) 1, LVN 1 was observed crushing medications in one small bag, poured the crushed medications into a medication cup, then mixed with apple sauce. The medications were as follows: 1.Aspirin (a medication used to prevent a blood clot from forming in a deep vein) 81 milligrams (mg, unit of weight) two chewable tablets 2.Calcium 600 mg plus Vitamin D (a nutrient that helps your body use calcium to build strong bones) 200 mg one tablet two times a day 3.Iron 325 mg one tablet two times a day 4. Docusate Sodium (a medication used treat constipation) 100 mg one tablet one time a day 5.Memantine Hydrochloride (a medication used to treat memory loss) 10 mg one tablet 6.Tylenol (a medication used for pain) two 500 mg two tablets two times a day During a concurrent observation and interview on 2/24/2025 at 9:15 am with LVN 1 in Resident 95's room, LVN 1 was observed administering the prepared crushed medications to Resident 95 followed by water to drink. Resident 95 was observed swishing the water in her mouth right after administration of medication and proceeded to spit the medications onto a spit basin. LVN 1 stated she was not able to determine how much dose and what medications were spit out by Resident 95. LVN 1 stated medications can only be crushed with physician orders indicating to do so. LVN 1 stated when there were no orders to crush medications and the resident can benefit from crushing the medications, LVN 1 stated LVN 1 would contact the physician to get an order. During an interview on 2/25/2025 at 10:35 am, with Resident 95's primary care physician (PCP), the PCP stated Resident 95 does not have difficulty swallowing. PCP stated he was not aware Resident 95 cannot medications as a whole pill. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/26/2025 at 11:34 a.m., with Director of Nursing (DON), DON stated medications are crushed according to physician orders. DON stated LVN 1 failed to follow policy of administering medications according to physician orders and crushed Resident 95's medications without an order indicating to do so. During a review of Resident 95's Admission Record (AR) dated 2/24/2025, the AR indicated facility admitted the Resident 95 on 1/25/2025 with diagnoses including but not limited to dementia a progressive state of decline in mental abilities) atherosclerosis (a disease that occurs when plaque builds up in the arteries, making them stiff and narrow) and hypertension (high blood pressure). During a review of Resident 95's Medication Administration Record (MAR) dated 2/1/2025- 2/28/2025, the MAR indicated no medication order to crush medications prior to administration. During a review of Resident 95's Order Summary Report (OSR), dated 2/24/2025, the OSR indicated no orders to crush medications since 1/25/2025 and indicated new order added on 2/24/2025. During a review of the facility's policy and procedure (P&) titled Administering Medications, dated April 2019, the P&P indicated medications are administered in accordance with prescriber orders . During a review of facility's policy and procedure (P&P) titled Crushing Medications, dated 4/2018, the P&P indicated medications shall be crushed only when appropriate consistent with physician orders .the guideline when crushing medications, crushing each medication separately is considered the best practice.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49947 Based on observation, interview, and record review, the facility failed to ensure residents were free of any significant medication errors (means the observed or identified preparation or administration of medications or biologicals which is not in accordance with the prescriber ' s order, manufacturer ' s specifications, and accepted professional standards) by: 1. Failing to rotate (a method to ensure repeated injections are not administered in the same area) subcutaneous (beneath the skin) insulin (a medication that regulates sugar in the blood) injections sites to two of two sampled residents (Residents 76 and 111) reviewed under the insulin care area. The deficient practice had the potential for adverse effect (unwanted, unintended result) of same site subcutaneous administration of insulin such as lipodystrophy (abnormal distribution of fat), bruising and pain. 2. a. Administering one (1) dose of expired insulin (a medication used to regular blood sugar levels) on 2/25/2025 by Licensed Vocational Nurse (LVN) 10 to Resident 37 in one (1) of four (4) observed medications carts (Medication Cart 2 Station 4.) b. Administering two (2) doses of expired latanoprost (a medication used for glaucoma [a condition of increased pressure in the eyeball]) eye drop by LVNs 11 and 12 between 2/23/2024 and 2/24/2025 to Resident 43 in one (1) of four (4) observed medications carts (Medication Cart 2 Station 4.) As a result, Resident 37 received one (1) dose of expired insulin on 2/25/2025 and Resident 43 received two (2) doses of expired latanoprost between 2/23/2025 and 2/24/2025 not in accordance with standards of practice. These deficient practices had the potential to cause Resident 37 to experience serious complications such as hyperglycemia (elevated blood sugar levels) diabetic coma (a life-threatening complication that can result from very high blood sugar or very low blood sugar levels); and to cause Resident 43 complications like blindness and eye infections, resulting in potential hospitalization and/or death. Findings: 1.a. During a review of Resident 76's Admission Record, the Admission Record indicated the facility admitted Resident 76 on 10/20/2023 with diagnoses that included, but not limited to type 2 diabetes mellitus (a disease that occurs when the glucose, also called blood sugar, is too high), neuropathy (damage, disease, or dysfunction of one or more nerves) and major depressive disorder (a mental health condition that causes persistent feelings of sadness and hopelessness). During a review of Resident 76's History and Physical (H&P), dated 10/25/2024, indicated the resident did not have the capacity to understand and make decisions. (continued on next page)

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	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canyon Oaks Nursing and Rehabilitation Center	22029 Saticoy Street Canoga Park, CA 91303

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 76's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 4/3/2024, the MDS indicated the resident had some impaired cognition, needed maximal assistance from staff for activities such as toileting, dressing, bathing and personal hygiene, and was on a high-risk drug class medication hypoglycemic (a group of drugs used to help reduce the amount of sugar present in the blood). During a review of Resident 76's Order Summary Report, the report indicated an order dated 9/12/2024, Insulin Glargine subcutaneous (SQ - in the fatty layer of the skin) Solution 100 units per milliliters (unit/ml, a unit of fluid volume) inject 12 units SQ at bedtime. During a review of Resident 76's 2/2025 Medication Administration Record (MAR) reviewed on 2/27/2025 at 10:30am, the MAR indicated insulin was administered on the following dates and sites: Insulin Glargine SQ 100 unit/ml subcutaneous solution: 2/1/2025 - abdomen - left upper quadrant (LUQ) 2/2/2025 - abdomen - left upper quadrant (LUQ) 2/3/2025 - abdomen - left upper quadrant (LUQ) 2/4/2025 - abdomen - left upper quadrant (LUQ) 2/5/2025 - abdomen - left upper quadrant (LUQ) 2/6/2025 - abdomen - left upper quadrant (LUQ) 2/7/2025 - abdomen - left upper quadrant (LUQ) 2/9/2025 - abdomen - left upper quadrant (LUQ) 2/10/2025 - abdomen - left upper quadrant (LUQ) 2/11/2025 - abdomen - left upper quadrant (LUQ) 2/12/2025 - abdomen - left upper quadrant (LUQ) 2/13/2025 - abdomen - left upper quadrant (LUQ) 2/16/2025 - abdomen - left upper quadrant (LUQ) 2/17/2025 - abdomen - left upper quadrant (LUQ) 2/18/2025 - abdomen - left upper quadrant (LUQ) 2/19/2025 - abdomen - left upper quadrant (LUQ) (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 02/27/25 at 11:27 am with Registered Nurse 1 (RN 1), reviewed MAR of Resident 76 with RN 1. RN 1 stated there were multiple instances where the injection sites of insulin were not rotated in 2/2025. RN 1 stated the sites of insulin administration should be rotated to prevent damage to the skin tissues of the resident. RN 1 stated the failure to follow the physician's order to rotate the insulin administration site is considered a medication error. During a review of the facility's recent policy and procedure titled, Adverse Consequences and Medication Errors, last reviewed on 1/15/2025, the policy and procedure indicated a medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer's specifications, or accepted professional standards and principles of the professional(s) providing services. During a review of the facility's recent policy and procedure titled, Insulin Administration, last reviewed on 1/15/2025, indicated injection sites should be rotated, preferably within the same general area (abdomen, thigh, upper arm). During a review of the facility provided medication insert instructions for Insulin Glargine, undated, the insert indicated to change (rotate) injection sites within the area chosen for each dose to reduce the risk of getting lipodystrophy (pits in the skin or thickened skin) and localized cutaneous amyloidosis (skin with lumps) at the injection sites. 1.b. During a review of Resident 111's Admission Record, the Admission Record indicated the facility admitted Resident 111 on 10/11/2024 with diagnoses that included, but not limited to type 2 diabetes mellitus (a disease that occurs when the glucose, also called blood sugar, is too high), and major depressive disorder (a mental health condition that causes persistent feelings of sadness and hopelessness). During a review of Resident 111's History and Physical (H&P), dated 1/9/2025, indicated the resident did have the capacity to understand and make decisions. During a review of Resident 111's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 12/27/2024, indicated the resident had the capacity to make herself understood and understand others, needed moderate assistance from staff for activities such as toileting, dressing, bathing and personal hygiene, and was on a high-risk drug class medication hypoglycemic (a group of drugs used to help reduce the amount of sugar present in the blood). During a review of Resident 111's Order Summary Report, the report indicated an order dated 11/30/2024 for Humulin R Injection Solution 100 u/ml. Inject as per sliding scale (sliding scale, increasing administration of the pre-meal insulin dose based on the blood sugar level before the meal) before meals and at bedtime. During a review of Resident 111's 12/2024 Medication Administration Record (MAR), the MAR indicated Humulin R Injection Solution 100 unit/ml subcutaneous solution insulin was administered on the following dates and sites: 12/2/2024 -11:30 am - abdomen - left lower quadrant (LLQ) (continued on next page)

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	555822	A. Building B. Wing	02/27/2025

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12/2/2024 - 9:00 pm - abdomen - left lower quadrant (LLQ) 12/3/2024 - 9:00 pm - abdomen - left lower quadrant (LLQ) 12/12/2024 - 11:30 am - abdomen - left lower quadrant (LLQ) 12/12/2024 - 4:30 pm - abdomen - left lower quadrant (LLQ) During a concurrent interview and record review on 02/27/25 at 11:30 am with Registered Nurse 1 (RN 1), reviewed Resident 111's MAR. RN 1 stated there were multiple instances where the injection sites of insulin were not rotated in 12/2024. RN 1 stated the sites of insulin administration should be rotated to prevent damage to the skin tissues of the resident. RN 1 also stated the failure to follow the physician's order to rotate the insulin administration site was considered a medication error. During a review of the facility's recent policy and procedure titled, Adverse Consequences and Medication Errors, last reviewed on 1/15/2025, indicated a medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer's specifications, or accepted professional standards and principles of the professional(s) providing services. During a review of the facility's recent policy and procedure titled, Insulin Administration, last reviewed on 1/15/2025, indicated injection sites should be rotated, preferably within the same general area (abdomen, thigh, upper arm). During a review of the facility provided medication insert instructions for Humulin R, undated, the insert indicated to rotate injection sites to reduce risk of lipodystrophy and localized cutaneous amyloidosis. 43455 2. During a review of Resident 37's Admission Record (a document containing demographic and diagnostic information) dated 2/25/2025, the Admission Record indicated Resident 37 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including type 2 diabetes mellitus 2 (DM2 - a condition that affects how the body processes blood sugar.) During a review of Resident 37's Order Summary Report (a report listing the physician order for the resident) dated 2/25/2025, the report indicated Resident 37 was prescribed insulin Fiasp (rapid-acting insulin) Flextouch (type of injection pen) pen to inject 8 units ([un] - a measure of dosage for insulin) subcutaneous ([SQ] - under the skin) before meals for DM twice a day before breakfast and dinner, starting 9/5/2024. During a review of Resident 19's MAR ([MAR] - a document of the medications administered to a resident that is part of the resident ' s permanent medical record], for February 2025, the MAR indicated Resident 37 was prescribed insulin Fiasp to give 8 un SQ before each meals for DM twice a day before breakfast and dinner, at 6:30 a.m. and 4:30 p.m., and that Resident 37 received one (1) dose of expired insulin Fiasp from LVN 10 on 2/25/2025 at 6:30 a.m. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 43's Admission Record dated 2/25/2025, the Admission Record indicated Resident 37 was originally admitted to the facility on [DATE] with diagnoses including glaucoma. During a review of Resident 43's Order Summary Report, dated 2/25/2025, the report indicated Resident 43 was prescribed latanoprost 0.005% to instill one (1) drop both eyes at bedtime for glaucoma, starting 12/29/2021. During a review of Resident 43's MAR for February 20245, the MAR indicated Resident 43 was prescribed latanoprost 0.005% to instill one (1) drop both eyes at bedtime for glaucoma, at 9 p.m., and that Resident 43 received the following doses by the following licensed nurses: LVN 11 - one (1) dose on 2/23/2025 at 9 p.m. LVN 12 - one (1) dose on 2/24/2025 at 9 p.m During an observation on 2/25/2025 at 12:08 p.m., in Medication Cart 2 Station 4, in the presence of LVN 5, the following medications were found either stored in a manner contrary to their respective manufacturers' requirements, not labeled with an open date as required by their respective manufacturers' specifications, expired and not discarded, or stored and labeled contrary to facility policies, currently accepted laws and professional principles: a. One open Fiasp Flextouch pen for Resident 37 was found stored at room temperature and labeled with a date indicating use began on 1/28/2025. According to the manufacturer ' s product labeling, opened Fiasp Flextouch pens should be stored at room temperature up to 86 degrees Fahrenheit and used or discarded within 28 days of opening or once storage at room temperature began. b. One open latanoprost eye drop bottle for resident 43 was found stored at room temperature and labeled with a date indicating use began on 1/12/2025. According to the manufacturer's product storage and labeling, opened latanoprost bottles may be stored at room temperature up to 77 degrees Fahrenheit and used or discarded within 6 weeks of opening/use. During a concurrent interview, LVN 5 stated the Fiasp Flextouch pen for Resident 37 was opened on 1/28/2025. LVN 5 stated insulins are usually good for 28 days and lose potency (effectiveness) and expire beyond that date. LVN 5 stated the Fiasp pen expired on 2/24/2025 and one (1) expired dose was administered to Resident 37 on 2/25/2025. LVN 5 stated administering expired insulin will not be effective in treating residents blood sugar levels and can harm Resident 37 by causing high blood sugar levels leading to coma hospitalization , and death. LVN 5 stated the Fiasp Flextouch pen needed to be removed from the medication cart and discarded to ensure expired insulin was not administered to Resident 37. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LVN 5 stated the latanoprost eye drop bottle for Resident 43 was opened on 1/12/2025. LVN 5 stated eye drop medications are usually good for 30 days after opening. LVN 5 stated administering expired latanoprost to Resident 43 will not be effective in treating the resident ' s glaucoma and lead to worsening of the glaucoma by increasing the pressure in the eye and causing blindness, and potentially cause eye infections since the dropper of the bottle is no longer sterile beyond the expiration date. LVN 5 stated medications that are expired must be removed from the medication cart to prevent accidental use. LVN 5 stated the latanoprost bottle was expired and needed to be removed from the medication cart and discarded to ensure expired latanoprost was not administered to Resident 43 after the expiration date. During an interview on 2/26/2025 at 11:34 a.m., with the Director of Nursing (DON), in the presence of Clinical Nurse Consultant (NC) 1, DON stated that the facility failed to dispose of expired medications per policy and procedures. The DON stated that open insulin vials and pens are usually good for 28 days and giving expired insulin to residents will not be effective due to decreased potency causing high or low blood sugar levels and leading to potential coma, hospitalization , and death. DON stated that using expired eye medications will not be effective in treating glaucoma due to decreased potency and lead to possible infections due to decreased sterility (free of infections.) During a review of facility ' s policy and procedures (P&P), titled Administering Medications, last reviewed 1/15/2025, the P&P indicated Medications are administered in a safe and timely manner, and as prescribed. The expiration/beyond use date on the medication label is checked prior to administering. During a review of review facility ' s P&P titled, Medication Storage and Labeling, last reviewed 1/15/2025, the P&P indicated: Multi-dose vials that have been opened or accessed are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial. During a review of facility ' s P&P, titled Abridged List of Medications with Shortened Expiration Dates, [undated,] the P&P listed the following: Fiasp - Beyond Use Date Notes after accessing insulin for first use - pen 28 days. Latanoprost - Beyond Use Date Notes - 6 weeks (42 days) after opening or moving to room temp. During a review of facility ' s P&P, titled Did you Know the steps to perform an internal expired med inventory audit, [undated,] the P&P listed the following: To avoid incorrect medication expiration dates in your ward stock .due to expired meds. Enact a system to regularly check meds for correct expiration dates and to remove expired drugs. See the abridged list of select meds with unique expirations below: Xalatan (brand name for Latanoprost): 6 week expiration (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Insulin: Multi-dose vials (MDV)and pens stored in refrigerator until first dispense. In-use MDVs stored in med cart: 28 days room temperature. In-use pens: 28 days room temperature. During a review of the facility ' s P&P titled Adverse consequences and Medication Errors, last reviewed 1/15/2025, the P&P indicated: A medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician ' s orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services. Examples of medication error include: Failure to follow manufacturer instructions and/or accepted professional standards. A 'significant medication-related error' is defined as: Requiring hospitalization Resulting in death.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 43455 Based on observation, interview, and record review the facility failed to: 1. Label one (1) Forteo (a medication used for osteoporosis [a condition in which bones become weak, brittle, making them prone to breakage) pen (an injection device containing the medication) for Resident 295 with an open date in accordance with the manufacturers' requirements in one (1) of two (2) inspected medication rooms (Medication Room Station 2). 2. Label one (1) fluticasone and salmeterol (medication used to treat Chronic Obstructive Pulmonary Disease [COPD]- a disease that blocks air flow and makes breathing difficult]) inhalation powder (form of medication that is inhaled) for Residents 23, and one (1) insulin (medication used to regulate blood sugar levels) Humulin R (short-acting insulin) vial (glass bottle containing insulin) for Resident 111 with an open date in accordance with the manufacturers' requirements in one (1) of four (4) inspected medication carts (Medication Cart 2 Station 4). 3. Label one (1) insulin Lantus (a long-acting insulin) pen with a pharmacy label, in accordance with medication labeling requirements, in one (1) of two (2) inspected medication rooms (Medication Room Station 1). 4. Remove and discard from use one (1) expired insulin Fiasp (rapid-acting insulin) Flextouch (type of injection pen) pen for Resident 37 and one (1) latanoprost (a medication used for glaucoma [a condition of increased pressure in the eyeball]) eye drop bottle for Resident 43, in accordance with manufacturers' requirements and facility policies, in one (1) of four (4) inspected medication carts (Medication Cart 2 Station 4). These deficient practices increased the risk that Residents 23, 37, 43, 111, and 295 could have received medications that had become ineffective or toxic due to improper storage or labeling, accidentally used due to improper labeling, possibly leading to health complications resulting in infections, hospitalization or death. Findings: During an observation on 2/24/2025 at 1:14 p.m., in Medication Room Station 2, in the presence of Registered Nurse (RN) 1, the following medications were found either stored in a manner contrary to their respective manufacturers' requirements or not labeled with an open date as required by their respective manufacturers' specifications and facility policy and procedures: 1. One (1) open and used Forteo pen for Resident 295 was found stored in the refrigerator in Medication Room Station 2 and not labeled with a date on which use began. According to the manufacturer label on the pen, the label indicated to Throw away 28 days after first use. According to the manufacturer's product storage and labeling, Forteo pens need to be refrigerated and used or discarded after 28 days of use. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview, RN 1 stated Forteo pen for Resident 295 was not labeled with a date indicating when use began, and the label on the pen indicated to discard after 28 days of use. RN 1 stated when opening multi-dose (providing more than one dose) medications, the date opened should be indicated to know when the pen should be discarded. RN 1 stated Forteo pen can lose its potency (effectiveness) after 28 days and when used in error beyond that date will not be effective in treating Resident 295's osteoporosis and harm the resident by potentially resulting in brittle bones and breakage. During an observation on 2/24/2025 at 1:59 p.m., in Medication Room Station 1, in the presence of Licensed Vocational Nurse (LVN) 3, the following medications were found either stored and labeled in a manner contrary to their respective manufacturers' requirements, contrary to facility policies and currently accepted laws and professional principles: -One unopened insulin Lantus pen was found in the refrigerator and not labeled with a pharmacy label and resident name. According to facility policy and professional standards of practice, all medications including insulin pens must be labeled with a pharmacy label that includes the resident name to prevent accidental use and sharing of medications. According to the manufacturer's product information, Lantus pens must never be shared between patients as sharing poses a risk for transmission (transfer of a disease from one person to another) of blood-borne pathogens (organisms in the blood that can cause infections). During a concurrent interview, LVN 3 stated the Lantus pen was not labeled with a pharmacy label and LVN 3 did not know which resident the pen belonged to. LVN 3 stated per facility policy all medications must have a pharmacy label indicating who the medication belongs to and directions for use, so that they are not accidentally administered to the wrong resident. LVN 3 stated that any medication without a pharmacy label should be immediately returned to pharmacy for proper labeling. During an observation on 2/25/2025 at 12:08 p.m., in Medication Cart 2 Station 4, in the presence of LVN 5, the following medications were found either stored in a manner contrary to their respective manufacturers' requirements, not labeled with an open date as required by their respective manufacturers' specifications, expired and not discarded, or stored and labeled contrary to facility policies, currently accepted laws and professional principles: 1. One (1) open and used fluticasone and salmeterol inhalation powder device stored for Resident 23 was found stored at room temperature without a protective foil pouch and not labeled with a date on which use at room temperature outside the foil pouch began. According to the manufacturer's product storage and labeling, opened fluticasone and salmeterol inhalation powder device can be stored at room temperature between 68 and 77 degrees Fahrenheit and used or discarded one (1) month after removal from the moisture-protective foil pouch. 2. One open Fiasp Flextouch pen for Resident 37 was found stored at room temperature and labeled with a date indicating use began on 1/28/2025. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the manufacturer's product labeling, opened Fiasp Flextouch pens should be stored at room temperature up to 86 degrees Fahrenheit and used or discarded within 28 days of opening or once storage at room temperature began. 3. One open latanoprost eye drop bottle for resident 43 was found stored at room temperature and labeled with a date indicating use began on 1/12/2025. According to the manufacturer's product storage and labeling, opened latanoprost bottles may be stored at room temperature up to 77 degrees Fahrenheit and used or discarded within 6 weeks of opening/use. 4. One (1) unopened Humulin R vial for Residents 111 was found stored at room temperature without a date indicating when storage at room temperature began. According to the label on the prescription bottle the label indicated to discard unused medication after 31 days. According to the manufacturer's product storage and labeling, opened Humulin R insulin vials can be stored at room temperature below 86 degrees Fahrenheit and discarded after 31 During a concurrent interview, LVN 5 stated the fluticasone and salmeterol inhalation powder device for Resident 23 was opened, used and not labeled with a date indicating when use began. LVN 5 stated once a multi-dose medication is opened, it must be labeled with the date opened to know when it expires and when it should be discarded. LVN 5 stated it was unknown when the fluticasone and salmeterol inhalation powder device was opened therefore unknown when it would expire and need to be discarded. LVN 5 stated inhalation powders are usually good for 30 days and lose potency and expire beyond that date, and if not labeled then expired inhalation powder can be used in error. LVN 5 stated administering expired fluticasone and salmeterol to Resident 23 will not help in improving breathing and can cause breathing complications, such as shortness of breath, potentially requiring hospitalization . LVN 5 stated the fluticasone and salmeterol inhalation powder device needed to be discarded and replaced with a new one from pharmacy to ensure expired insulin was not administered to Resident 23. LVN 5 stated the Fiasp Flextouch pen for Resident 37 was opened on 1/28/2025. LVN 5 stated insulins are usually good for 28 days and lose potency and expire beyond that date. LVN 5 stated the Fiasp pen expired on 2/24/2025 and one (1) expired dose was administered to Resident 37 on 2/25/2025. LVN 5 stated the Humulin R vial for Resident 111 was stored at room temperature, not opened and should have either been stored in the refrigerator until opened or labeled with a date when storage at room temperature began. LVN 5 stated it was unknown when the Humulin R vial was stored at room temperature therefore unknown when it would expire and need to be discarded to prevent accidental use. LVN 5 stated administering expired insulin will not be effective in treating residents blood sugar levels and can harm Resident 37 and 111 by causing high blood sugar levels leading to coma (a life-threatening complication that can result from very high blood sugar or very low blood sugar levels) hospitalization , and death. LVN 5 stated the Humulin R vial and Fiasp Flextouch pen needed to be removed from the medication cart and discarded to ensure expired insulin was not administered to Resident 37 and 111. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LVN 5 stated the latanoprost eye drop bottle for Resident 43 was opened on 1/12/2025. LVN 5 stated eye drop medications are usually good for 30 days after opening. LVN 5 stated administering expired latanoprost to Resident 43 will not be effective in treating the resident's glaucoma and lead to worsening of the glaucoma by increasing the pressure in the eye and causing blindness and lead to blindness, and potentially cause eye infections since the dropper of the bottle is no longer sterile beyond the expiration date. LVN 5 stated medications that are expired must be removed from the medication cart to prevent accidental use. LVN 5 stated the latanoprost bottle was expired and needed to be removed from the medication cart and discarded to ensure expired latanoprost was not administered to Resident 43 after the expiration date. During an interview on 2/26/2025 at 11:34 a.m., with the Director of Nursing (DON), in the presence of Clinical Nurse Consultant (NC) 1, DON stated that the facility failed to store and label the above medications properly and dispose of unlabeled and expired medications per policy and procedures. DON stated that opened medications, such as insulins, eye drops, and breathing treatments, should be dated with an open date label to know when they should be disposed of, otherwise they are considered expired. DON stated that open insulin vials and pens are usually good for 28 days and giving expired insulin to residents will not be effective due to decreased potency causing high or low blood sugar levels and leading to potential coma, hospitalization , and death. DON stated that insulin pens without pharmacy label should be immediately returned to pharmacy for re-labeling and unlabeled insulin pens are a safety concern because it can accidentally be used for the wrong resident. The DON stated that giving expired breathing medication to residents will be ineffective due to decreased potency and make breathing more difficult, possibly leading to stoppage of breathing. DON stated that using expired eye medications will not be effective in treating glaucoma due to decreased potency and lead to possible infections due to decreased sterility (free of infections.) During a review of facility's policy and procedures (P&P), titled Administering Medications, last reviewed 1/15/2025, the P&P indicated Medications are administered in a safe and timely manner, and as prescribed. 12. The expiration/beyond use date on the medication label is checked prior to administering. When opening a multi-dose container, the date opened is recorded on the container. 13. Insulin pens are clearly labeled with the resident's name or other identifying information. During a review of review facility's P&P titled, Medication Storage and Labeling, last reviewed 1/15/2025, the P&P indicated: 1. Labeling of medications and biologicals dispensed by the pharmacy is consistent with applicable federal and state requirements and currently accepted pharmaceutical practices. 2. The medication label includes, at a minimum: a. Medication name b. Prescribed dose c. Strength (continued on next page)

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	555822	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. Expiration date e. Resident's name f. Route of administration g. Appropriate instructions and precautions 5. Multi-dose vials that have been opened or accessed are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial. 8. If medication containers have missing, incomplete, improper or incorrect labels, contact the dispensing pharmacy for instructions regarding returning or destroying these items. During a review of facility's P&P, titled Abridged List of Medications with Shortened Expiration Dates, [undated,] the P&P listed the following: Fluticasone/Salmeterol - Beyond Use Date Notes - 30 days after removal from foil pouch. Fiasp - Beyond Use Date Notes after accessing insulin for first use - pen 28 days. Humulin R - Beyond Use Date Notes after accessing insulin for first use - 31 days. Latanoprost - Beyond Use Date Notes - 6 weeks (42 days) after opening or moving to room temp. During a review of facility's P&P, titled Did you Know the steps to perform an internal expired med inventory audit, [undated,] the P&P listed the following: To avoid incorrect medication expiration dates in your ward stock .due to expired meds. Enact a system to regularly check meds for correct expiration dates and to remove expired drugs. Perform this internal inventory inspection at least monthly to avoid enforcement action via F-tag 761. See the abridged list of select meds with unique expirations below: oXalatan (brand name for Latanoprost): 6 week expiration oInsulin: Multi-dose vials (MDV)and pens stored in refrigerator until first dispense. In-use MDVs stored in med cart: 28 days room temperature. In-use pens: 28 days room temperature The State Operations Manual mentions drug expiration 8 separate times To cite deficient practice at F761 .investigation will generally show that the facility failed to ensure that all drugs .are labeled in accordance with professional standards, including expiration dates. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Areas to check should include Medication carts, Med rooms, refrigerator Record an open date on all opened meds (liquids, topicals, insulin vials, insulin pens, eye drops, etc.)

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	555822	A. Building B. Wing	02/27/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 34659 Based on observation, interview, and record review, the facility failed to ensure food items on the tray line (a system of food serving in which a tray is moved along an assembly line to ensure a resident gets their prescribed diet) provide a record of food temperatures when the Assistant Dietary Supervisor (ADS) failed to document the temperature all foods on the tray line. These failures had the potential to result in harmful bacteria growth and cross contamination (a transfer of harmful bacteria from one place to another or one object to another) that could lead to foodborne illness (illness caused by food contaminated with bacteria, viruses, and other toxins) in 143 medically compromised residents who received food from the kitchen. Findings: During a kitchen tray line observation on 2/26/2025 at approximately 11:25 a.m., observed ADS checking the temperatures of the food on the tray line. The ADS took the following food temperatures: 1. soup - 175? F degrees Fahrenheit (? F, a unit of measure for temperature) 2. beef - 175? F 3. vegetable - 170? F 4. starch (rice) - 170? F 5. gravy - 166? F 6. chicken - 196? F 7. pureed (cooked food that has been ground, pressed, blended to the consistency of a creamy paste) beef - 173? F 8. pureed vegetable - 170? F 9. pureed rice - 170? F 10. diced (cut into small portions with a knife) beef - 160? F 11. salad - 36? F 12. milk - 36? F 13. Juice - 39? F 14. yogurt - 39? F (continued on next page)

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	555822	A. Building B. Wing	02/27/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	15. fish - 162? F 16. cottage cheese - 39? F 17. beans - 163? F 18. mashed potatoes - 173? F 19. diced chicken - 175? F The ADS took the following temperatures but did not record them: 1. fish 2. cottage cheese, 3. diced chicken, 4. beans, 5. mashed potatoes During a concurrent interview and record review with the ADS on 2/26/25 at 2:33 p.m., reviewed the kitchen Food Temperature Log with surveyor notes. The ADS verified that the fish, cottage cheese, diced chicken, beans, and mashed potatoes were taken but not recorded. The ADS stated they should be added to the Food Temperature Log to ensure that the food temperatures are not at dangerous levels with the potential for a food borne illness. During a concurrent interview and record review with the Dietary Supervisor (DS) on 2/26/2025 at 3:40 p.m., reviewed the kitchen Food Temperature Log. The DS stated all foods on the tray table should be documented on the Food Temperature Log. The DS stated the purpose of the Food Temperature Log is to have a record of food temperatures to ensure food is served within the regulation range. The DS stated documenting all food temperatures ensures that all foods served are safe and would not cause a food borne illness. During an interview with the Director of Nursing (DON) on 2/27/2025 at 8:35 a.m., they stated the purpose of the kitchen Food Temperature Log is to ensure food served from the facility's kitchen is at the right temperature. The DON stated food served too hot could potentially burn a resident's mouth, if too cold would not be palatable (pleasant to taste). The DON stated temperatures should be documented to ensure food served by the kitchen to residents is safe and does not place them at risk for a food borne illness. During a review of the facility's policy and procedure titled, Food Temperatures, last reviewed 1/15/2025, indicated the temperatures will be taken and properly recorded prior to service of each meal.

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	555822	A. Building B. Wing	02/27/2025

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 49947 Based on observation, interview, and record review the facility failed to maintain electronic medical administration records (EMAR) in accordance with accepted professional standards and practices by failing to ensure all licensed nurses charted accurately the administration of the medication Gemtesa (medication for overactive bladder [an organ that holds urine]) from 2/11/2025 to 2/19/2025 to one of three sampled residents (Resident 112) reviewed during the unnecessary medication task This deficient practice resulted in inaccurate documentation in Resident 112's medical record. Cross-reference F755 Findings: During a review of Resident 112's Admission Record, the Admission Record indicated the facility admitted Resident 112 on 6/15/2023 with diagnoses that included, but not limited to Alzheimer's Disease (progressive state of decline in mental abilities), Parkinson's Disease (a progressive neurological [relating to the brain, spinal cord, and nerves] disorder that affects movement, balance, and coordination), major depressive disorder (a mental health condition that causes persistent feelings of sadness and hopelessness), and a history of falling. During a review of Resident 112's Physician's Progress Note, dated 1/7/2025, the Physician's Progress Note indicated Resident 112 had the capacity to understand and make decision and had urinary incontinence (inability to control urine flow) with improvement in bladder spasms (sudden uncontrollable squeezing of the bladder) and urination when on Gemtesa. The progress note indicated the resident to continue using Gemtesa. During a review of Resident 112's Minimum Data Set (MDS - an assessment and care screening tool) dated 12/18/2024, indicated Resident 112 was able to understand others and make herself understood. The MDS indicated Resident 112 needed moderate assistance on staff for bathing, dressing, and toileting. During a review of Resident 112's Physician's Orders, the order indicated Gemtesa oral tablet - give 75 milligrams (mg - a unit of measurement) by mouth one time a day for overactive bladder was discontinued on 2/19/2025. During a review of Resident 112's Bladder Incontinence (inability to control the flow of urine from the bladder) Care Plan (CP) initiated on 6/26/2023 and last revised on 7/8/2024, the CP indicated goals to keep Resident 112 clean, dry and free of odors and to reduce episodes of incontinence through the next review date of 03/18/2025. During a review of Resident 112's Electronic Medical Administration Record (EMAR - online charting system), the EMAR indicated the charting code 3 entered by the Licensed Vocational Nurses (LVN) indicates Hold/Progress Note MD Notification, and a check mark indicates Administered. The EMAR further indicated the following entries for the medication Gemtesa: (continued on next page)

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	555822	A. Building B. Wing	02/27/2025

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 2/11/2025 at 9:00am a code of 3 was documented by LVN 4. - On 2/12/2025 at 9:00am a check mark was documented by LVN 9. - On 2/13/2025 at 9:00am a check mark was documented by LVN 8. - On 2/14/2025 at 9:00am a check mark was documented by LVN 8. - On 2/15/2025 at 9:00am a check mark was documented by LVN 9. - On 2/16/2025 at 9:00am a check mark was documented by LVN 9. - On 2/17/2025 at 9:00am a code of 3 was documented by LVN 6. - On 2/18/2025 at 9:00am a code of 3 was documented by LVN 4. - On 2/19/2025 at 9:00am a code of 3 was documented by LVN 6. During a review of Resident 112's Progress Notes, the Progress Notes indicated the following documentation for the medication Gemtesa: - On 2/11/2025 LVN 4 entered awaiting refill from RX, medicine NA. - On 2/17/2025 LVN 6 entered medication unavailable. MD notified. - On 2/17/2025 LVN 4 entered medicine NA, awaiting refill from RX. - On 2/17/2025 LVN 6 entered medication unavailable. MD notified. During a concurrent interview and record review on 2/26/2025 at 10:20 am with LVN 8 of Resident 112's EMAR, LVN 8 confirmed she worked on 2/13/2025 to 2/14/2025 and the medication Gemtesa was not available but accidently check marked in the EMAR that Gemtesa was given. LVN 8 indicated it is extremely important to be careful and accurate when charting in the EMAR so other nurses would know the medication was not available. During a concurrent interview and record review on 2/26/2025 at 11:00 am with LVN 9 reviewed Resident 112's EMAR. LVN 9 confirmed she worked on 2/12/2025, 2/15/2025 and 2/16/2025 and the medication Gemtesa was not available on those days but does not remember why Gemtesa was checked off as given. LVN 9 confirmed the check marks were documented in error. LVN 9 stated the EMAR is a legal document and it is very important to be accurate when charting so other nurses know if the resident received the medication or not. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on 2/26/2025 at 1:47 pm with LVN 4, LVN 4 stated on 2/11/2025 the bubble pack (a card that packages doses of medication within small, clear, plastic bubbles that is punched out to administer to a resident) for Gemtesa was completely empty and indicated a 3 in the EMAR and wrote that the medication was NA (LVN 4 clarified NA meant not available) and waiting for delivery from RX (LVN 4 clarified RX meant pharmacy). LVN 4 then stated when she worked again on 2/18/2025, the bubble pack was still empty and indicated a 3 in the EMAR again, requested a refill from the pharmacy again and then spoke with Resident 112's family member (FM 2) to inform him that the medication has been unavailable for several days. LVN 4 stated FM 2 stated he was never told in advance that the medication was out and was going to call Resident 4's pharmacy. LVN 4 stated she was unaware why other LVNs indicated they administered Gemtesa on 2/12/2025 -2/16/2025 on the EMAR when the medication was not available on 2/11/2025 and 2/18/2025. LVN 4 further stated the Gemtesa should have been followed up by the other LVNs to minimize the number of days the Resident 112 went without Gemtesa. During an interview on 2/26/2025 at 2:15pm with Registered Nurse (RN) 1, RN 1 stated medicine in bubble packs must be reordered when there are about 7 tablets left to give time for any insurance issues and for the medication to arrive before the current stock runs out. RN 1 further stated if LVN 8 and LVN 9 charted correctly, Resident 112's may have received a replenished supply sooner. During a review of the facility provided Policy and Procedure (P&P) titled, Charting and Documentation, last reviewed 1/15/2025, indicated the documentation in the medical record will be objective, complete and accurate. During a review of the facility's P&P titled, Charting and Documentation, last reviewed 1/15/2024, indicated medications administer is to be documented in the resident medical record. The P&P indicated documentation in the medical record will be objective, complete, and accurate. The P&P indicated entries may only be recorded in the resident's clinical record by licensed personnel. The P&P further indicated documentation of procedures and treatments will include care-specific details, including: a. The date and time the procedure/treatment was provided. b. The name and title of the individual(s) who provided the care. c. The assessment data and/or any unusual findings obtained during the procedure/treatment. d. How the resident tolerated the procedure/treatment. e. Whether the resident refused the procedure/treatment. f. Notification of family, physician, or other staff, if indicated; and g. The signature and title of the individual documenting.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38469 Based on observation, interview, and record review, the facility failed to: 1. Ensure a leftover blueberry muffin from the previous day was removed from the resident`s bedside for one of one (Resident 96) sampled resident. This deficient practice had the potential to result in contamination of the blueberry muffin which could lead to foodborne illness (also called food poisoning, illness caused by eating contaminated food) if the blue berry muffin is ingested (consumed). 2. Follow their Oxygen Administration, policy and procedure by failing to label an oxygen tubing with the date and time of when it was last changed for one of two sampled residents (Resident 345) reviewed under oxygen. This deficient practice had the potential to place Resident 345 at increased risk of infection and cause complications associated with oxygen therapy. 3. Implement policy on Handwashing - Hand Hygiene (a simple and essential hygiene practice that helps prevent the spread of germs and infections) when Treatment Nurse 2 (TN 2) failed to use alcohol-based hand rub (ABHR- antimicrobial solution containing at least 70% alcohol used to reduce the number of microorganisms on hands) after removing Personal Protective Equipment (PPE - gloves) during wound care for one of two (2) sampled residents (Resident 32) investigated for tube feeding. These deficient practices had the potential to increase the risk of spreading infection to other residents. This failure had the potential to increase the risk of spreading infection. 4. Maintain and prevent infection protocols when Licensed Vocational Nurse (LVN) 2 did not perform hand washing before preparation and administration of medication for one of one resident (Resident 31. This failure had the potential to increase the risk of spreading infection. Findings: 1. During a review of Resident 96's Admission Record, the Admission Record indicated the resident was admitted to the facility on [DATE], with diagnoses including dementia (a progressive state of decline in mental abilities) and metabolic encephalopathy (a change in how your brain works due to an underlying condition). (continued on next page)

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	555822	A. Building B. Wing	02/27/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 96`s Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 12/19/2024, the MDS indicated the resident`s cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was intact. The MDS also indicated that the resident required moderate assistance with shower and supervision with oral hygiene, toileting hygiene, shower, upper and lower body dressing and personal hygiene. During a concurrent observation and interview with Resident 96 on 02/24/2025 at 10:49 a.m., observed a blueberry muffin on the bedside table, uncovered and exposed to air. Resident 96 stated that the blueberry muffin was served during breakfast from the previous day. During an interview and record review on 02/24/25 at 11:23 a.m., with the Dietary Supervisor (DS), reviewed the menu for the week 2/23/2025 to 3/1/2025 (Cycle 18) which indicated that a blueberry muffin was served during breakfast on 2/23/2025. The DS stated that the facility does not allow residents to store left over food from their meal trays. The DS stated that yesterday (2/23/2025), blueberry muffin was served to Resident 96. The DS stated that leftover food had to be discarded after two hours as it is no longer safe for the resident to consume beyond that time and may cause foodborne illnesses. During a follow up observation on 02/24/2025 at 11:30 a.m., with the DS, in Resident 96's room, observed a blueberry muffin on the bedside table uncovered and exposed to air. The DS stated that the blueberry muffin was from the breakfast menu from the previous day. During a review of the facility`s policy and procedures titled Food Receiving and Storage, last reviewed on 1/15/2025, the policy and procedures indicated that .food shall be received and stored in a manner that complies with safe food handling practices .(Danger Zone- means temperatures above 41 degree Fahrenheit and below 135 degrees Fahrenheit that allow the rapid growth of pathogenic microorganisms that can cause foodborne illness). Potentially Hazardous Foods (PHF) or Time/Temperature Control for Safety (TCS) Foods held in the danger zone for more than 4 hours may cause a foodborne illness outbreak if consumed . 44309 2. During review of Resident 345`s Admission Record, the admission record indicated that the facility originally admitted the resident on 12/1/2023, and readmitted on [DATE], with diagnoses including chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), and acute (short term) respiratory failure (when not enough oxygen passes from your lungs to your blood) with hypoxia (a medical condition that occurs when there is an inadequate supply of oxygen to the body's tissues). During a review of Resident 345's Minimum Data Set (MDS-a resident assessment tool) dated 2/18/2025, 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 345 required partial/moderate assistance (helper does less than half effort) for upper body dressing, and personal hygiene. The MDS further indicated that resident 345 was receiving intermittent (on and off) oxygen therapy upon admission and while a resident inside the facility. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 345's Order Summary Report (physician order) dated 2/11/2025, the order summary report indicated to administer oxygen at two (2) liters per minute via nasal canula (NC- (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) as needed for hypoxia/shortness of breath. The order summary report indicated to change the oxygen tubing (including NC, and/or mask, and storage bag) every week and as needed and date the tubing and storage bag. During an observation on 2/24/2025 at 10:15 a.m. inside Resident 345`s room, the resident was observed sitting on her bed. Resident 345 was receiving oxygen at two (2) liters per minute via NC. However, the oxygen tubing did not have a label including the date and time of when it was last changed. During a concurrent observation and interview on 2/24/2025 at 10:20 a.m., with Certified Nursing Assistant 2 (CNA 2) inside Resident 345's room, CNA 2 stated that Resident 345`s oxygen tubing did not have a label with the date and time of when it was last changed.  During an interview on 2/24/2025 at 10:30 a.m., with Licensed Vocational Nurse 2 (LVN2), LVN 2 stated Resident 345`s oxygen tubing did not have a label with the date and time of when it was last changed. LVN2 stated that the facility staff is required to change the oxygen tubing once a week and label with the date and time of when it was changed. LVN2 stated the potential outcome of not changing patient`s oxygen tubing once per week as ordered by the physician is placing the resident at risk for infection. During an interview on 2/27/2025, at 2:15 p.m., with the Director of Nursing (DON), the DON stated that the facility staff is required to change the oxygen tubing once per week as ordered by the physician and label the tubing with the date and time it was changed. The DON stated Resident 345`s oxygen tubing did not have the date and time of when it was last changed, and the potential outcome is the increased risk of infection for Resident 345. During a review of the facility's policy and procedure (P&P) titled Oxygen Administration, last reviewed on 1/15/2025, the P&P indicated that the purpose of this procedure if to provide guidelines for safe oxygen administration. Review the resident`s care plan to assess for any special needs of the residents. Oxygen tubing and humidifier (if in use) will be changed and labeled every seven days and as needed. 47883 4. During a review of Resident 32's Admission Record, the Administration Record indicated that the facility initially admitted Resident 32 on 1/3/2025 and readmitted the resident on 1/19/2025 with diagnoses including pneumonitis (lungs tissue inflammation, swelling, and irritation), 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), multiple fracture of ribs. During a review of Resident 32's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 1/25/2025, the MDS indicated that the resident had intact cognition (undamaged mental abilities, including remembering things, making decisions, concentrating, or learning).The MDS further indicated that Resident 32 required maximal assistance from staff with oral and personal hygiene and was dependent on two or more helpers for other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 32 History and Physical (H&P), dated 1/20/2025, the H&P indicated Resident 32 did not have the capacity to understand and make decisions. During a review of Order Summary Report dated 2/25/2025, the Order Summary Report indicated physician order for cleanse tube stoma site (the surgically created opening in the abdomen where a feeding tube is inserted) with normal saline (a sterile, clear solution containing 0.9% sodium chloride [NaCl]in water) and cover with dry clean dressing daily dated 1/20/2025. During concurrent observation and interview on 2/26/1025 at 9:24 a.m., in Resident 32 room with Treatment Nurse 2 (TN 2), Resident 32 observed in their chair. Observed TN 2 washed her hands, donned (putted on and use PPE [gloves, gown] properly to minimize the risk of exposure) gown and gloves, removed old dressing, discarded old dressing, doffed (took off PPE [gloves, gown] in the way that avoid self-contamination) gloves, washed her hands and donned new gloves. TN 2 cleaned the tube stoma site with normal saline and doffed the gloves and without sanitizing her hands with ABHR, TN 2 donned new gloves and proceeded to cover tube stoma site with dry clean dressing. TN 2 stated that she needs to wash her hands before and after providing treatment and after removing old dressing. TN 2 stated she was not aware that she needs to sanitize her hands each time she took off the gloves. During an interview on 2/27/2025 at 11:35 a.m., with the Infection Preventionist (IP), the IP stated when staff is providing wound care for residents, the practice is to sanitize the hands with ABHR each time the nurse removes gloves. The IP stated TN 2 should have sanitized her hand after removing used gloves and before putting new gloves on. The IP stated this deficient practice may increase risk of spreading infection in the facility. During an interview on 2/27/2025 at 12:03 p.m., with the Director of Nursing (DON), the DON stated according to the facility policy Handwashing -Hand Hygiene all staff should follow the hand hygiene procedure and sanitize their hands with ABHR each time they removed the gloves. The DON stated this was important to prevent the spread of infection. During a review of the facility policy named Handwashing -Hand Hygiene, last reviewed on 1/15/2025, the policy indicated: This facility considers hand hygiene the primary means to prevent the spread of infection . Use an alcohol-based hand rub containing at least 70% alcohol; or alternatively, soap and water for following situations: . after removing gloves. 43455 5. During a concurrent observation and interview on 2/24/2025 at 10:05 am, at medication cart one in Nursing Station 2 with Licensed Vocational Nurse (LVN) 2, LVN 2 was observed pulling out medication from the cart drawer and popped out pills from blister pack (unit-dose packaging of medications) into a medication cup. LVN 2 did not perform hand washing or hygiene before handling medication. LVN 2 stated ten medications were prepared to be administered to Resident 31. During an interview on 2/27/2025 at 2:23 pm with LVN 2, LVN 2 stated he did not wash or sanitize his hands before medication preparation and administration. LVN 2 stated handwashing and sanitizing were important to prevent spread of infection. LVN 3 stated hands are carriers of germs, and it was possible to spread infection if standard precaution was not practiced. (continued on next page)

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	02/27/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/27/2025 at 3:38 pm with Infection Preventionist (IP), the IP stated the standard infection prevention policies and procedures applies to all staff working at the facility. The IP stated the facility also follows the standard precautions recommendation of Center for Disease Control (CDC) when providing care. During a review of facility's policy and procedure (P&P), titled Administering Medications, dated 4/2019, the P&P indicated the staff follows facility's established infection and control procedures .hand washing is a procedure for medication administration. During a review of facility's P&P, titled Handwashing-Hand Hygiene, dated 7/2023, the P&P indicated hand hygiene practice is the facility's practice to prevent the spread of infection .the use of alcohol-based hand rub (ABHR) or soap and water before preparing and handling medications.