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	05/07/2026

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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observations, interview, and record review, the facility failed to dispose garbage and refuse properly when the dumpster (a movable waste container designed to be brought and taken away by special collection vehicle, or to a bin that a specially designed garbage truck lifts) surroundings had sticky black spills. This failure had potential to attract birds, flies, insects, pests and possibly spread infection to 152 of 152 facility residents. Findings:ˆ During a concurrent observation and interview on 5/5/2026 at 8:15 a.m. with the Dietary Supervisor (DS), observed dry and black sticky substance on the grounds in front and to the right of both dumpsters. The left dumpster had black substance dripping from it. The DS stated she cannot identify the source or nature of the black stains and sticky substances. During an interview on 5/5/2026 at 8:58 a.m. with the Director of Maintenance (DOM), the DOM stated the black dumpster is for disposal of regular, non-hazardous trash. The DOM stated he observed there was wet, black substance on the ground in the right front corner of the two black dumpsters. The DOM stated the dumpster area should be clean and without spillage from the dumpsters. The DOM stated the spillage odor can be unpleasant. The DOM stated it was important for the dumpster area to be free from spillage because spills can attract insects, cockroaches, rats that could enter the facility and potentially cause or spread infection to residents. During a review of the facility's P&P titled, Sanitation last reviewed 1/26/2026, the P&P indicated, Garbage and refuse containers are in good condition, without leaks, and waste is properly contained in the dumpster/compactors with kids (or otherwise covered).Areas used for garbage disposal are free from odors and waste fats, and maintained to prevent pests.

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on observation, interview, and record review, the facility failed to provide an environment thatˆwasˆfree from accident hazards for three of seven residents (173, 160, and Resident 2) investigated under the accident care areaˆbyˆfailing to: a. Provide upper bed rail padding for a resident with a history of seizures (a suddenˆsurge of abnormal electrical activity in the brain, leading to a range of symptoms like muscle spasms, loss of consciousness) to Resident 173. This deficient practice placed Residentˆ173ˆatˆanˆincreased risk for injuries.ˆ b. Ensureˆthatˆvitamin A&Dˆointmentˆ(a topical skin protectant and moisturizer)ˆand unknown white paste inˆan unlabeled medicine cupˆwas notˆleft atˆthe Resident 160's bedside.ˆ This deficient practice had the potential toˆplace Resident 160ˆandˆother residentsˆat anˆincreasedˆriskˆfor applicationˆor ingestionˆofˆunprescribed A&D ointmentˆandˆunknownˆsubstanceˆwhich can resultˆallergic reactionˆor poisoning.ˆ c. Ensure that Resident 2 had bilateral floor mats while in bed as ordered by the physician.ˆˆ This failure had the potential to result in injury toˆResidentˆ2.ˆ ˆ Findings:ˆ a. During a review of Residentˆ173'sˆadmission Record, theˆadmission Recordˆindicated the facilityˆadmitted Residentˆ173ˆonˆ4/29/2026 with diagnoses includingˆtraumatic subduralˆhemorrhageˆ(bleeding between the brain and the tough outer membrane that covers it, caused by a head injury)ˆand type 2 diabetesˆ(DM-a disorder characterized by difficulty in blood sugar control and poor wound healing).ˆˆ During a review of Residentˆ173'sˆHistory and Physical (H&P), datedˆ1/26/2026, theˆH&PˆindicatedResidentˆ44's had diagnoses including seizures and tracheostomyˆ(surgically created opening in the front of the neck leading directly into the tracheaˆ[windpipe]ˆto help a person breathe). The H&P further stated Resident 44 was unable to make his own decisions.ˆˆ During a review of Residentˆ173's Minimum Data Set (MDS – a resident assessment tool) datedˆ5/14/2026,ˆthe MDS indicated the resident understood others andˆmade himselfˆunderstood.ˆThe MDS furtherˆindicatedˆResidentˆ173ˆneeded supervision/touchˆassistanceˆ(helperˆprovides verbal cuesˆand/or touchˆassistance)ˆfromˆfacility staff for activitiesˆsuch as eating, oral hygiene, and upper body dressing.ˆ During a review of Residentˆ44's Physician's Order, the Physician's order dated 4/29/2026, indicated an order for levetiracetam oral tablet (medication to help prevent seizures)ˆ500 mg (milligrams – a unit of measurement)ˆgive 1 tablet by mouth two times a day for seizure prophylaxis (prevention). During an observation onˆ5/4/2026 atˆ8:26 a.m. in Residentˆ173's room, Residentˆ173ˆwasˆsitting upˆin bed. The upper bed rails on Residentˆ173's bed were made of metal and were not padded.ˆˆ During a concurrent observation and interview onˆ5/4/2026 atˆ8:31ˆa.m. in Residentˆ173's room withˆLicensed Vocationalˆ Nurse (LVNˆ7),ˆLVNˆ7ˆstated Residentˆ173's bed did not have the neededˆpadding on hisˆbedrails to keep him safe during aˆpotentialˆseizure.ˆLVNˆ7ˆstatedˆthe padding is to protect the resident's head andˆbody from the uncontrolled shaking from seizures.ˆˆ During aˆconcurrentˆinterviewˆand record reviewˆonˆ5/7/2026 at 1:45 p.m. with the Director of Nursing (DON), the DONˆreviewed Resident 173'sˆphysician's orders. The DONˆstatedˆResident 173 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was takingˆtheˆmedicationˆlevetiracetamˆas a seizure precaution andˆfacility staffˆshould have applied padding to his siderails to protect his head and body in the event Resident 173 had a seizure.ˆ During a review of the facility providedˆPolicy and Procedure (P&P)ˆtitled, Seizure Precautions last reviewed on 1/21/2026, the P&Pˆindicatesˆto provide a safe environment and pad side rails as indicated.ˆˆˆ b. During a review of Residentˆ160'sˆadmission Record, the admission Recordˆindicated the facility admitted ˆResidentˆ160ˆon 9/8/2026ˆwith diagnosesˆthat includedˆatheroscleroticˆheart disease (theˆbuildupˆofˆfats, cholesterol, and other substances in and on the wallsˆthat carriesˆblood away from the heart),ˆchronic pain syndromeˆ(long lastingˆpain), and anxiety disorder (chronic, uncontrollable, and excessive worrying about everyday things that interferes with daily life, far beyond normal stress).ˆ During a review of Residentˆ160's MDS dated [DATE], the MDS indicated Residentˆ160ˆmakesˆself-understoodˆandˆable toˆunderstandˆothers.ˆThe MDS indicated Residentˆ160ˆrequiredˆsubstantial/maximalˆassistanceˆ(helper doesˆmore than ˆhalf the work)ˆwithˆoral hygiene, toileting hygiene, personal hygiene, shower/bathe self, upper and lower body dressing, andˆrequiredˆsupervision or touchingˆassistanceˆwith eating.ˆ During review of Resident 160's History and Physical (H&P), datedˆ9/11/2023, the H&Pˆindicatedˆ Residentˆ160ˆhad the capacity toˆmakeˆown decisions.ˆ During a concurrent observation and interview on 5/4/2026 atˆ10:19 a.m., in Resident 160's room, with Licensed Vocational Nurse (LVN)ˆ1,ˆobservedˆtwoˆopen individually packaged A&D ointmentˆandˆhalf-filledˆunlabeledˆmedication cupˆwith white pasteˆsubstance,ˆwithˆaˆspoon held up by the white pasteˆon Resident 160'sˆright side bedside table.ˆLVN 1ˆstatedˆthatˆtheˆvitamin A&Dˆand medicine cup with unknown substance shouldˆnotˆbe at the bedside.ˆLVN 1ˆstatedˆthat once opened, theˆunusedˆvitaminˆA&Dˆin the individual packet should beˆdisposed ofˆand not re-usedˆbecause of potential contaminationˆthat could result inˆspread ofˆinfection.ˆLVN 1ˆstatedˆthat the unknown substanceˆin the medication cupˆposed a risk for Residentˆ160, other residents and everyone who enters Resident 160's roomˆfor potential harm. LVNˆ1 explained thatˆthe unlabeled, unidentified substance in the medication cup canˆbe ingestedˆon accident ifˆmistakenˆforˆsomethingˆedible.ˆˆ During an interviewˆon 5/7/2026ˆat 10:39 a.m.ˆwith the Director of Nursing (DON), the DONˆstatedˆthatˆthe vitamin A&Dˆand unlabeled unknown substance in the medication cupˆleft at Resident 160'sˆbedsideˆwasˆinappropriate.ˆThe DONˆstatedˆthe items should have beenˆdisposedˆafterˆif they wereˆexcess supply from what wasˆapplied to Resident 160.ˆThe DONˆstatedˆtheˆunknown substance left at the bedside couldˆbe mistaken asˆfoodˆby another resident whoˆfinds it at the bedsideˆandˆingestsˆitˆwhich could result in harm.ˆThe DON alsoˆstatedˆthatˆan allergic reaction could occur ifˆtheˆvitamin A&Dˆleft at the bedsideˆwere used by another residentˆwhoˆmay be confused andˆdoˆnot knowˆthey are allergic to it.ˆˆˆ During a review of the facility's policy and procedure (P&P) titled, Safety Plan and Supervision of Residentsˆlast reviewedˆ1/26/2026, the P&Pˆindicatedˆ Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision andˆassistanceˆto prevent accidents are facility-wide priorities.Due to their complexity and scope, certain resident risk factors and environmental hazards are addressed in dedicatedˆpolicesˆand procedures. These (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	risk^factors and environment hazards include the^following:.poison control.^ During a review of the facility's P&P titled, Administering Medications last reviewed 1/26/2026, the P&P indicated Medications ordered for^a particular resident may not be administered to another resident, unless permitted by state^law and facility policy, and approved by the Director of Nursing Services.Medications should only be removed from the cart at the time of administration and must^not be left unattended.^ c. During a review of Resident 2's^admission Record, the Admission^Record^indicated the facility admitted Resident 2 to the facility on 8/5/2024 with diagnoses including but not limited to acute kidney failure^(a sudden inability of the kidneys to filter waste from the blood), muscle weakness, and unspecified dementia (a progressive state of decline in mental abilities).^ During a review of the MDS dated [DATE], the MDS indicated Resident 2 had a BIMS^(Brief Interview for Mental Status-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident)^score of 2 (a score of 0 - 7, severely impaired cognition), functional impairment affecting daily functions on upper and lower extremities, and use of wheelchair.^ During a review of Resident 2's History and Physical (H&P), dated 4/11/2026, the H&P^indicated^Resident 2^had^history and diagnosis of leg weakness, and did not have capacity to make own decisions due to senile (decline in mental or physical abilities associated with old age) dementia.^ During a review^of^Resident 2's^physician's^order, dated^12/11/2024, the^physician's^order^indicated^a low bed with bilateral landing mat^when in bed.^^ During a review of Resident 2's Care Plan (CP), revised 3/10/2026, the CP^indicated^Resident 2 had risk for falls related to generalized weakness, history of multiple falls, and dementia.^The CP indicated an intervention to place a floor pad next to Resident 2's bed.^ During an observation on^5/4/2026^at^2:00^p.m.^in Resident 2's room, Resident 2 was^lying^in bed^positioned on right side with no bilateral floor mats on either side of the bed.^ During an^interview on 5/6/2026 at 3:31^p.m.^with Certified Nursing^Assistant (CNA)^2, CNA 2 stated^Resident 2 is not on high fall risk^precautions, that was a long time^ago. CNA^was^not aware of an order^for bilateral landing floor mat when Resident 2^was^in bed.^ During a^concurrent observation and interview on 5/6/2026 at 3:36^p.m.^with^Licensed^Vocational Nurse (LVN) 2^in^Resident 2's^room, Resident 2 was lying in bed^with no bilateral^landing^floor mats.^LVN 2^stated^if there is a^physician's^order for bilateral landing floor mats, they should be in place.^ During a concurrent interview and record review on 5/6/2026 at 3:42^p.m.^with^LVN 6,^Resident 2's physician order dated 12/11/2024 was reviewed.^The physician's^order^indicated^low bed with bilateral landing mats when in bed.^LVN 6^stated Resident 2 had^been^free^of falls^for^about^6^months;^the order should have^been^discontinued.^^ During a concurrent interview and record review^on 5/7/2026 at 11:25^a.m.^with^the Director of (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nursing (DON), Resident 2's physician orderˆdated 12/11/2024ˆwas reviewed. The physician orderˆindicatedˆthe use of low bed with bilateral landing mat when in bed. The DONˆstatedˆtheˆfacility staff should have followedˆand implementedˆthe physician order.ˆ During a review of the facility's policy and procedure (P&P) titled, Falls and Fall Risk, Managing, dated March 2018, the P&P indicatedˆin collaboration with physician theˆstaff willˆidentify andˆimplement relevant interventions .to try to minimize serious consequences of falling,ˆand re-evaluate fall risk interventionsˆfor current relevance.ˆˆ ˆ ˆ ˆ

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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** Based on observation, interview, and record review the facility failed to: 1.Administer a form of multiple vitamin (a medication used as a dietary supplement to provide essential vitamins, minerals, and other nutritional elements) to one (1) of six (6) observed residents (Resident 69) during medication administration task, as ordered by Resident 69's physician. 2. Replace one open used medication emergency kit ([ekit] - storage container for emergency use medications) within 72 hours of opening the kit on 4/27/2026, in one (1) of three (3) inspected medication carts (Medication Cart 1 Station 2.) 3. Reconcile (the process of comparing transactions and activity to supporting documentation) two (2) medication ekits containing controlled medications (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 May 2026, in two (2) of two (2) inspected medication rooms (Medication Room Station 2 and Medication Room Station 4.) As a result, medication administration, control and accountability of CM and availability of medications did not follow state and federal regulations and facility policy and procedures. These failures had the potential to result in Resident 69 receiving suboptimal (less than standard) care and experiencing adverse effects (unwanted, uncomfortable, or dangerous effects that a medication may have), in addition to increasing 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. Findings: During an observation on 5/4/2026 at 10:02 a.m., in Medication Cart 2 Station 3, Licensed Vocational Nurse (LVN) 1 was observed administering multi-vitamin with minerals tablet orally to Resident 69. Resident 69 was observed swallowing the multivitamin with mineral tablet with a bottle of Boost (a nutritional drink.) During an observation on 5/4/2026 at 12:15 p.m., with LVN 3, in Medication Room Station 4 there was: -One (1) medication ekit containing CMs, labeled [NAME].REF-53 with a date indicating pharmacy prepared the kit on 3/5/2026, without an accountability log for the reconciliation of CM inventory at every shift change for May 2026. During a concurrent interview, LVN 3 stated that all CMs, including medication ekits containing CMs, should be reconciled at every shift. LVN 3 stated that the ekit labeled [NAME].REF-53 contained CMs in Medication Room Station 4 and was not reconciled at every shift in May 2026. LVN 3 stated it was important to account for all CMs to ensure accountability, prevent CM diversion and accidental exposure of harmful substances to residents. During an observation on 5/4/2026 at 12:35 p.m., with Registered Nurse (RN) 1, in Medication Room Station 2 there was: -One (1) medication ekit containing CMs, locked with a green tag imprinted with 05291598, and labeled with a date indicating pharmacy prepared the kit on 2/10/2026, without an accountability log for the reconciliation of CM inventory at every shift change for May 2026. During a concurrent interview, RN 1 stated that all CMs, including medication ekits containing CMs, should be reconciled at every shift. RN 1 stated that the ekit locked with a green tag imprinted with 05291598 contained CMs in Medication Room Station 2 and was not reconciled at every shift in May 2026. RN 1 stated it was important to account for all CMs to ensure accountability, prevent CM diversion and accidental exposure of harmful substances to residents. During an observation on 5/4/2026 at 12:50 p.m., with LVN 4, in Medication Cart 1 Station 2, there was: -One (1) open medication ekit labeled S18 with a document indicating the ekit was opened on 4/27/2026 at 11:39 p.m. During a concurrent interview, LVN 4 stated the medication ekit labeled S18 was opened on 4/27/2026, used and awaiting replacement for a new one from pharmacy. LVN 4 stated the mediation ekit should have been replaced with a new one from pharmacy within 24 hours of opening the kit. LVN 4 stated the medication ekit was not replaced with a new one within 24 hours and this failure could lead to negative consequence (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	for residents by not having emergency medications readily available during emergency situations causing resident harm and potential hospitalization. During an interview 5/4/2026 at 1:15 p.m., with LVN 1, LVN 1 acknowledged the physician order for Resident 69 indicated to give multivitamin not containing minerals. LVN 1 stated LVN failed to administer the correct multivitamin as prescribed by Resident 69's physician. LVN 1 stated administering multivitamins with minerals to Resident 69 may not be beneficial to their health and may cause adverse effects. LVN 1 stated this was not according to physician orders and considered a medication error. During an interview 5/4/2026 at 1:35 p.m., with the Director of Nursing (DON), the DON stated LVN 1 failed to administer multivitamin without minerals to Resident 69, according to physician orders. The DON stated this was considered a medication error. The DON stated Resident 69 may be at risk of not being able to tolerate the additional minerals from the multivitamin. The DON stated licensed nurses should follow facility medication administration guidelines to ensure physician orders are followed and the right medications are administered to residents. 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 Medication Room Station 2 and 4 were not reconciled at each shift change in May 2026. The DON stated that the facility will immediately implement an accountability log for reconciliation of ekits at each shift change in Medication Room Station 2 and Station 4. During the same interview, 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 Cart 1 Station 2 was open and used on 4/27/2026 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 a review of Resident 69's admission Record (a document containing demographic and diagnostic information,) dated 5/4/2026, the admission Record indicated Resident 69 was originally admitted to the facility on [DATE] with a diagnosis including anemia (a condition often caused by iron deficiency where the body doesn't have enough healthy red blood cells to carry oxygen to tissues, resulting in fatigue, weakness, and shortness of breath) and dysphagia (difficulty swallowing often leading to malnutrition.) During a review of Resident 69's (Medication Administration Record ([MAR] - a record of mediations administered to residents), for May 2026, the MAR indicated Resident 69 was prescribed multiple vitamin tablet orally once a day for supplementation, to give at 9 a.m. During a review of the facility's policy and procedures (P&P), titled Emergency Pharmacy Service and Emergency Kits (E-KITS), last reviewed 1/21/2026, the P&P indicated: In states that allow replacing used doses of medication, the nurse replaces the medication in the appropriate area of the kit within 24 hours of opening or next scheduled delivery, or as required by state regulation. During a review of the facility's P&P titled Controlled Substances, last reviewed 1/21/2026, the P&P indicated that CMs are substances that have an accepted medical use (medications which fall under U.S Drug Enforcement (DEA) Schedules II-V,) have a potential for abuse, ranging from low to high, and may also lead to physical or psychological dependence. These medications are subject to special handling, storage, disposal, and recordkeeping at the nursing care center, in accordance with federal and state laws and regulations. 7. At each shift change, a physical inventory of all CMs as defined by state regulation, is conducted by two licensed clinicians and is documented on an audit record. During a review of the facility's P&P titled Controlled Medication Storage, last reviewed 1/21/2026, the P&P indicated: Medications included in the DEA classification as CSs are subject to special handling, storage, disposal and record keeping in the nursing care center in accordance with federal, state and other applicable laws and regulations. 6. At each shift change, a physical inventory of all Schedule II, including refrigerated items, is conducted by two licensed nurses or per state regulation and is documented on the CS accountability record or verification of CS count report. During a review of the facility's P&P titled Medication Administration General Guidelines, last reviewed 1/21/2026, the P&P indicated that Medications are administered as prescribed . Medication Preparation 3. Prior to (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	administration, review and confirm medication orders for each individual resident on the MAR. Compare the medication and dosage schedule on the resident's MAR with the medication label. Medication Administration 1.Medications are administered in accordance with written orders of the prescriber. 9 Verify medication is correct three (3) times before administering the medication. a. When pulling the medication package from med cart b. When dose is prepared c.Before dose is administered.

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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. Based on observation, interview, and record review the facility failed to: a.Not store food items with medications in the medication refrigerator for one (1) of two (2) inspected medication rooms (Medication Room Station 4.) b. Label the Neosporin (over-the-counter triple antibiotic ointment used to prevent infections in minor cuts, scrapes, and burns) ointment and properly store the ointment for resident self-administration in accordance with the facility policy and procedure on Medication Labeling and Storage, for one (1) of one (1) sampled resident (Resident 160). These deficient practices increased the risk of unsafe medication administration for Resident 60 and the cross contamination (the physical transfer of harmful bacteria, viruses, or allergens from one surface or food item to another) between food and medications for residents in the facility, resulting in health complications such as infections and medication adverse effects (unwanted, uncomfortable, or dangerous effects that a medication may have.) Findings: a.During an observation on 5/4/2026 at 12:15 p.m., in Medication Room Station 4, in the presence of Licensed Vocational Nurse (LVN) 3, the medication refrigerator contained several medications for the residents in Station 4 together with one (1) carton of orange juice and one (1) carton of apple juice. During a concurrent interview, LVN 3 stated the medication refrigerator should only be used to store medications and not to store food items together with medications. LVN 3 stated there was a risk of cross contamination when storing food with medications. During an interview on 5/4/2026 at 1:35 p.m., with the Director of Nursing (DON,) the DON stated that the facility failed to not store two (2) juice carton boxes together with medications stored in the medication refrigerator in Medication Room Station 4. The DON stated the refrigerator was intended to be used for medication storage only, and storing food with medications together in the same refrigerator was not according to facility policy and procedures and increased the risk of cross contamination. During a review of the facility's policy and procedures (P&P), titled Storage of Medication, dated 1/21/2026, the P&P indicated: Medications and biologicals are stored safely, securely, and properly.to support safe effective drug administration. 13. Refrigerated medications should be kept in closed and labeled containers.and all medications segregated from fruit juices, applesauce, and other foods used in administering medications. Any other foods.should not be stored in this refrigerator. b. During a review of Resident 160's admission Record, the admission Record indicated the facility admitted Resident 160 on 9/8/2026 with diagnoses that included atherosclerotic heart disease (the buildup of fats, cholesterol, and other substances in and on the walls that carries blood away from the heart), chronic pain syndrome (long lasting pain), and anxiety disorder (chronic, uncontrollable, and excessive worrying about everyday things that interferes with daily life, far beyond normal stress). During a review of Resident 160's Minimum Data Set (MDS - a resident assessment tool) dated 3/10/2026, the MDS indicated Resident 160 makes self-understood and able to understand others. The MDS indicated Resident 160 required substantial/maximal assistance (helper does more than half the work) with oral hygiene, toileting hygiene, personal hygiene, shower/bathe self, upper and lower (continued on next page)

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	body dressing, and required supervision or touching assistance with eating. During review of Resident 160's History and Physical (H&P), dated 9/11/2023, the H&P indicated Resident 160 had the capacity to make own decisions. During a concurrent observation and interview with Resident 160 on 5/7/2026 at 11:52 a.m. in Resident 160's room with Registered Nurse (RN) 1, observed an unlabeled box of Neosporin on a tray table (a height-adjustable rolling table designed to slide over a bed or chair) placed in front of Resident 160. Resident 160 stated she applies the Neosporin on sores she would get and pointed to a marked redness on the left side of her face, near her right ear, as one of the sites she applies the ointment. When asked of other sites she applies the medication, Resident 160 responded with elevated voice and stated, I don't know where else I put it on, but I have many. Resident 160 could not specify when or how frequent she applies the medication, only able to state that she applies the medication to prevent her sores from becoming infected. During a concurrent observation and interview with Resident 160 on 5/7/2026 at 1:37 p.m. in Resident 160's room with the Director of Nursing (DON), observed Resident 160 lying in bed with the tray table placed in front of Resident 160. On the tray table is the unlabeled Neosporin box. Resident 160 emptied the unlabeled Neosporin tube from the Neosporin box. Resident 160 stated she applies the Neosporin she applies it herself when she needs it. Resident 160 stated she needed a new supply since it was almost empty. During an interview on 5/7/2026 at 1:45 p.m. with the DON, the DON stated that the Neosporin in Resident 160's room should have a label. The DON stated that medications for resident self-administration are provided by the facility and are supposed to have a label with the resident's name, the name of the drug and other pertinent information per physician orders. The DON stated medication without a label should never be left at the bedside. The DON stated that if a medication was brought in by the resident or family member, the medication would be sent home and an order for the medication would be obtained from the physician and supplied by the pharmacy with a label. The DON stated that in situations where medication from outside was brought in the facility by the resident or family was approved by physician for the resident to have, it would also need to have a label from pharmacy. The DON stated medication label is important because it informs which resident the medication was ordered for and all the other information about the medication in accordance with the physician's order. The DON stated that unlabeled medication poses a safety issue. The DON explained that when unlabeled, a medication may be used by someone who could be allergic to it and have an allergic reaction. During a review of the facility's P&P titled, Medication Labeling and Storage last reviewed 1/26/2026, the P&P indicated Labeling of medications and biologicals dispensed by the pharmacy is consistent with applicable federal and state requirements and currently accepted pharmaceutical practices. The medication label includes, at a minimum: a. medication name (generic and/or brand); b. prescribed dose; c. strength; d. expiration date, when applicable; (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	e. resident's name f. route of administration; and g. appropriate instructions and precautions. If medication containers have a missing, incomplete, improper or incorrect labels, contact the dispensing pharmacy for instructions regarding returning or destroying these items. During a review of the facility's P&P titled, Medications Brought to the Facility by the Resident/Family last reviewed 1/16/2026, the P&P indicated, If a medication is not otherwise available and/or it is determined to be essential to the resident's life, health, safety, or well-being, to be able to take the medication from outside, the director of nursing services, the nursing staff, with support of the attending physician and consultant pharmacist, shall check to ensure that.c. the contents of each container are labeled in accordance with established policies; and d. the contents of each container have been verified by a licensed pharmacist. During a review of the facility's P&P titled, Self-Administration of Medications last reviewed 1/26/2026, the P&P indicated, Self-administered medications are stored in a safe and secure place, which is not accessible by other residents. If safe storage is not possible in the resident's room, the medications of the residents permitted to self-administer are stored on a central medication cart or in the medication room. A licensed nurse transfers the unopened medication to the resident when the resident requests them.The nursing staff routinely checks self-administered medications and removes expired, discontinued, or recalled medication.

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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. Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and food preparation practices in the kitchen when:ˆ 1. Oranges, tomatoes,ˆbroccolisˆand prepared juice were labeled with incorrect date.ˆ 2. Prepared juiceˆwas left stored in the refrigerator beyondˆtheˆfor-useˆdate. 3. Surfaces of the cutting boards were scratched and had gouges along the edges. 4. Temperatures of foodˆitemsˆon the tray lineˆ(a system of foodˆservingˆin whichˆa tray is moved along an assembly line toˆensure a resident gets their prescribed diet)ˆwereˆnot obtained in accordance with the facility policy and procedure on Meal Service, by failing to ensure: a. [NAME] 1ˆobtainedˆthe temperatureˆof all food on the tray line.ˆ b. Dietary Aide 1 (DA 1)ˆrecorded the temperature of all food items on theˆbreakfast/lunchˆFoodˆTemperatureˆmonitoringˆlog.ˆ These failures had the potential to result in harmful bacterialˆgrowth and cross contaminationˆ(transfer of harmful bacteria from one place to another or one object to another)ˆthat could lead to foodborne illnessˆ(a disease caused by consuming food or drinks that are contaminated by germs or chemicals)ˆinˆ151 of 152ˆmedically compromised residents who received food from the kitchen.ˆˆ Findings:ˆ 1-3. During an initial kitchen tour observation on 5/4/2026 at 7:55 am., in the presence of the Dietary Supervisor (DS), observed oranges, tomatoes, and broccoli stored in a container with a sticker label dated 6/1/2026. Also observed cups filled with red liquid and single serving of pre-packaged prune juice on a tray with a label dated 5/3/2026 inside the reach in refrigerator #1 and observed separate cups filled with red liquid on a tray with a label dated 5/5/2026 inside reach in refrigerator #2. During an interview with the DS in the kitchen on 5/4/2026 at 8:10 a.m., the DS stated that produce container labels indicated when the produce delivery date. The DS stated the labels on the oranges, tomatoes, and broccoli storage container were incorrect and should have been labeled 5/1/2026 instead of 6/1/2026. The DS stated the person who created the label made a mistake. The DS stated that accurate labeling is important to track freshness, safety and quality of food. The DS stated that they follow First-In-First-Out (FIFO an inventory management where oldest produce are used first) method, so labeling the produce correct delivery dates is essential. During an interview with the DS in the kitchen on 5/4/2026 at 8:15 a.m., the DS stated the cups filled with red liquid in the reach in refrigerators were juice prepared to be served to the residents. The DS stated once juice is removed from its original container, it can be served until the following day. The DS stated prepared juices should be labeled with their use-by date. The DS stated the juices on the tray dated 5/3/2026 found in the reach in refrigerator #1 were prepared on 5/2/2026 and unserved juice should have been removed from the refrigerator and thrown away on 5/3/2026. The DS stated that leaving the juices in the refrigerator after the use-by date risked serving the juice to the residents. The DS stated serving juice by the designated use date is important to ensure the quality of the juice served to the residents. During a subsequent kitchen observation in the presence of the DS and interview with the DS on 5/5/2026 at 8:15 a.m. observed three (3) cutting boards, two (2) blue and one (1) green. The surfaces of the cutting boards were faded and white, scored with scratches and grooves all around the edges. The DS stated that food can get trapped in these areas, leading to bacterial growth that may contaminate the food prepared for the residents. During a review of the facility's policy and procedure (P&P) titled, Labeling and Dating of Foods last (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reviewed 1/26/2026, the P&P indicated, All food items in the storeroom, refrigerator, and freezer needs to be labeled and dated.Food delivered to facility needs to be marked with a received date. Note that the delivery sticker is dated, and it can serve as the delivery date for the product.Produce is to be dated with received date. During a review of the facility's P&P titled, Food Receiving and Storage last reviewed 1/26/2026, the P&P indicated, Foods shall be received and stored in a manner that complies with safe food handling practices.Beverages are dated when opened and discarded after twenty-four (24) hours. During a review of the facility's policy and procedure P&P titled, Sanitation last reviewed 1/26/2026, the P&P indicated, All utensils, counters, shelves and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosion, open seams, cracks and chipped areas that may affect their use or proper cleaning. 4. During a kitchen tray line observation onˆ5/06/2026ˆat approximatelyˆ11:45 a.m.,ˆobservedˆthe kitchen'sˆtray line. Observed [NAME] 1ˆchecking the temperatures of the food on the tray line.ˆCook 1ˆtook the following food temperatures:ˆ milk = 35ˆdegrees Fahrenheitˆ(ˆF, a unit of measure for temperature)ˆ juice =ˆ35 ˆˆ plainˆyogurtˆ= 35 ˆˆ pureeˆ(foods that are smooth with pudding like consistency)ˆvegetableˆ=ˆˆ175ˆˆˆ Pureeˆchicken =ˆ172 ˆˆ Puree pasta = 163 ˆˆ Minced and moist (diet featuring soft, cohesive foods that require minimal chewing)ˆchicken = 171 ˆˆ Minced and moist cabbage = 159 ˆˆ Minced and moist vegetable =ˆ162 ˆˆ ˆBite-sized (tender moist foods cut into smallˆpieces that are easy to chew) chicken = 160 ˆˆ ˆRegular (texture of food with no modifications and restrictions) chicken =ˆ200 ˆˆ ˆRegular noodles = 167 ˆˆ ˆRegular vegetable = 170 ˆˆ ˆGravy = 150 ˆˆ ˆRegular rice = 170 ˆˆ ˆRegular fish = 210 ˆˆ (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	^Vegetarian^entrée^= 180 ^^ ^Observed three foods^on the tray line^that the temperatures were not taken. Asked [NAME] 1 about the following foods that [NAME] 1 had not taken the temperatures:^ Salad greens^ Tuna^ Egg salad^ Observed the Dietary Supervisor (DS) took^the temperatures of^those foods.^^ During the tray line procedure, reviewed the^Breakfast/Lunch^Food^Temperature^logs. There were some entry lines that^were blank,^indicating^a temperature was not documented for that item.^^ During an interview with the DS on 5/06/2026 at 12:30 p.m., the DS^stated^all^hot and cold food temperatures should be taken and recorded^at the same time. The DS^stated^this was important for safety,^for ensuring those items are within the required temperature range to prevent residents from getting sick.^ During an interview with [NAME] 1, Dietary Aide 1 (DA 1), and^the Assistant [NAME] (Cook 2)^on 5/06/2026 at 1:20 p.m., [NAME] 1^stated^she^is in charge of^taking the temperature of the hot foods for the tray line.^Cook 2^stated^she^is in charge of^taking the temperature of the cold foods on the tray line.^Cook 2^stated^she should have recorded the temperatures of the lettuce, tuna, and egg salad. [NAME] 2^stated^she usually does^on other days.^^DA 1^stated^she was recording^temperatures for the hot foods that day. DA 1^stated^she did not record^all of^the food temperatures^at the time^Cook 1 was^checking the^temperatures.^DA 1^stated^this is important to make sure food reaches the required temperatures, that^the food is fully cooked and does not want any resident to get sick.^^ During an interview with the Director of Nurses (DON) on 5/07/2026 at 8:32 a.m., the DON stated^that the dietary staff should be checking the hot and cold food temperatures to^ensure they are within the required temperature ranges. The DON^stated^this was to ensure food is^safe for residents^and to ensure^that the food is palatable^(pleasant to taste)^to the residents.^^ During a concurrent interview and record review with the DS on^5/07/2026 at^11:49 a.m., the DS reviewed the Breakfast/Lunch Food Temperature log. The DS confirmed that the following foods were not recorded until^a later time after initially taking the food temperatures:^ Bite-sized noodles.^ Minced and moist noodles^ Fish^ Rice^ Bite-sized vegetable^ (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Milkˆˆ Juiceˆ ˆ The DSˆstatedˆthe dietary staffˆkeep a log,ˆtoˆensureˆthe hot and cold foodsˆareˆserved within the required temperatures.ˆThe DSˆstatedˆthe temperatures need to be recorded immediatelyˆafter taking the temperatures to ensure staff do not forget the values in the case they are recordingˆafter the fact.ˆThe DSˆstatedˆthis is to ensure the hot and cold foods are within the required temperature range.ˆ During a review of the facility's policy and procedure titled,ˆMeal Service, last reviewedˆ1/21/2026, indicatedˆthe food will be served on tray line at the recommended temperaturesˆand recorded onˆthe daily therapeutic menu in the temperature column of the regular food and next to the food item under the therapeutic diet column of each food served. The policyˆindicatedˆhot food serving temperatures must beˆat or above minimum holding temperature of 140 ˆ.ˆThe policyˆindicatedˆcold food items will be placed on the trays as close to serving time as possible to assure the temperature is below 41 ˆ.ˆ

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide a safe storage (refrigerator) designated for residents' food coming from outside sources. This failure had the potential to result in consumption of food that is unsafe and cause foodborne illness in residents who receive food from outside sources. Findings: During an interview with the Director of Nursing (DON) at 8:32 a.m., the DON stated there is no refrigerator for food brought in from families from outside the facility. During an interview with the Registered Dietician (RD) on 5/07/2026 at 1:31 p.m., the RD stated the facility cannot store food for residents brought in by their families (outside food) unless it is non-perishable such as packaged food or nuts. The RD stated, for hot and cold foods, they can be sitting out for two hours and then must be thrown out. When asked if it was an unreasonable request from residents to store their food, the RD stated the kitchen staff can store food from the outside for a one-time event later in the day such as a birthday. When asked why the facility does not have a separate refrigerator for residents outside food, she stated it is more liability if the facility does have a resident's refrigerator since the staff would have to check the food items and would need to monitor the refrigerator so other residents would not take other residents' food. The RD stated it is a lot of work to label the resident's food brought in from the outside. When asked how the facility's practice was not allowing residents to have a homelike environment, she stated the facility provides three meals and it is not necessary to have extra food items. During a review of Resident 97's admission Record (or face sheet, the front page of the chart that contains a summary of basic information about the resident), the admission Record indicated the facility originally admitted the resident to the facility on 3/28/2023 with diagnoses that included acute kidney failure (the sudden loss of kidney function, typically developing within a few hours or days). During a review of Resident 97's Minimum Data Set (MDS- a resident assessment tool), dated 3/25/2026, the MDS indicated Resident 97 was moderately 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 97 required supervision (helper provides verbal cues as resident completes activity) with eating. The MDS indicated Resident 97 was on a therapeutic diet (specially created diet such as low salt or fortified). During a review of Resident 97's Physician's Orders, the Physician's Orders indicated an order dated 2/27/2026 for fortified diet (diet that have vitamins, minerals added to increase their nutritional value and prevent weight loss) regular texture. During an observation and interview with Resident 97 on 5/07/2026 at 1:51 p.m. she stated she would like to store outside food in the facility for a day or two. Resident 97 stated she thought everyone would like to have their food stored as well. During a review of Resident 134's admission Record, the admission Record indicated the facility originally admitted Resident 134 to the facility on 1/23/2024 with diagnoses that included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body). During a review of Resident 134's MDS, dated [DATE], the MDS indicated Resident 134 was cognitively intact with skills required for daily decision making. The MDS indicated Resident 134 required setup or clean-up assistance (helper sets up or cleans up; resident completes activity) with eating. The MDS indicated Resident 134 was not on a therapeutic diet. During a review of Resident 134's Physician's Orders, the Physician's Orders indicated an order dated 3/23/2026 for regular diet, regular texture. During an interview with Resident 134 on 5/07/2026 at 1:52 p.m., Resident 134 stated he would like to have a refrigerator to store food brought in from the outside. During a review of Resident 106's admission Record, the admission Record indicated the facility originally admitted Resident 106 on 6/25/2021 and re-admitted on [DATE] with severe protein-calorie malnutrition (a life-threatening, advanced deficiency of essential protein and energy intake). During a review of Resident 106's MDS, dated [DATE], the MDS indicated Resident 134 was severely impaired in cognition with skills required for daily decision making. The MDS indicated Resident 106 was independent with eating. The MDS (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indicated Resident 106 was on a therapeutic diet. During a review of Resident 106's Physician's Orders, the Physician's Orders indicated an order dated 3/2/2026 for fortified diet puree texture (foods that are smooth with pudding like consistency). During an interview on 5/07/2026 at 1:52 p.m., Resident 106's Family Member 1 (FM 1). FM 1 stated she wished to have food she brings in from the outside to be stored at the facility. During an interview with the Administrator (ADM) on 5/07/2026 at 1:59 p.m., the ADM stated the facility tells families that hot and cold foods brought in by family have to be eaten within a certain time frame because they do not store residents' food in the facility. When asked why the facility does not store food, he stated it would be an added step to check food temperatures. The ADM stated it is important for residents to have the meals they want. The ADM stated he would consider holding a resident council meeting and meet with his team to see if something such as a refrigerator to store outside food would be achievable. The ADM stated he wants the residents to have as much a homelike environment as is possible. During a second interview with the DON on 5/07/2026 at 2:08 p.m. he stated there is no space to place a refrigerator dedicated to resident's food brought in from the outside. When asked if that is a valid reason for not having a refrigerator, the DON stated he would investigate that. The DON stated it is a reasonable request if a resident asks to store outside food they do not want to eat at that time it was brought. During an interview with the Dietary Supervisor (DS) on 5/07/2026 at 2:55 p.m., she stated there is no refrigerator to store residents outside food. The DS stated after the Covid-19 pandemic (also called Covid-19, a global outbreak of an infectious disease caused by the severe acute respiratory syndrome coronavirus), the corporate said the facility will no longer hold food for residents. The DS stated before Covid-19, the facility had a refrigerator designated to store residents' food brought in from the outside. The DS stated the kitchen staff maintained the refrigerator, including refrigerator temperature checks, and removing food that had been stored past the required time allowed. When asked if this is a reasonable request to store food for residents, she stated regardless of what she thinks, the policy indicates there is no outside food storage. During a review of the facility's policy and procedure titled, Food Brought by Family/Visitors, last reviewed 1/21/2026, indicated the following: 1.Food brought by family/visitors that is left with the resident to consume later is labeled and stored in a manner that it is clearly distinguishable from facility-prepared food. a. Non-perishable foods are stored in re-sealable containers with tight-fitting lids. Intact fresh fruit may be stored without a lid. b. Perishable foods cannot be stored in the facility and should be consumed within 2 hours to ensure resident safety. 10.Potentially hazardous foods that are left out for the resident without a source of heat or refrigeration longer than 2 hours are discarded.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview, and record review, the facility's interdisciplinary team (IDT - a coordinated group of experts from several fields who work together) failed to ensure a resident's self-administration of medication was appropriate and safe for one of one sampled resident (Resident 160) by failing to conduct the Self-Administration Safety Screen for Resident 160, who was self-administering a medication. This deficient practice placed resident at increased risk for negative outcome from potential improper use of medication, inappropriate treatment and medication mismanagement. Findings:^ During a review of Resident 160's admission Record (the front page of the chart that contains a summary of basic information about the resident), the admission Record indicated the facility admitted Resident 160 on 9/8/2026 with diagnoses that included atherosclerotic heart disease (the buildup of fats, cholesterol, and other substances in and on the walls that carries blood away from the heart), chronic pain syndrome (long lasting pain), and anxiety disorder (chronic, uncontrollable, and excessive worrying about everyday things that interferes with daily life, far beyond normal stress). During a review of Resident 160's Minimum Data Set (MDS - a resident assessment tool) dated 3/10/2026, the MDS indicated Resident 160 was able to make self-understood and able to understand others. The MDS indicated Resident 160 required substantial/maximal assistance (helper does more than half the work) with oral hygiene, toileting hygiene, personal hygiene, shower/bathe self, upper and lower body dressing, and required supervision or touching assistance with eating. The MDS indicated Resident 160 required substantial/maximal assistance with roll left and right, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, toilet/tub/shower transfer. During review of Resident 160's History and Physical (H&P), dated 9/11/2023, the H&P indicated Resident 160 had the capacity to make own decisions. During a concurrent interview and record review on 5/7/2026 at 10:39 a.m., with the Director of Nursing (DON), Resident 160's physician's order dated 2/24/2025 was reviewed. The physicians order indicated, May have Neosporin (over-the-counter triple antibiotic ointment used to prevent infections in minor cuts, scrapes, and burns) at the bedside per patient's request, every shift for Neosporin use. The DON explained that before a resident can self-administer a medication, the IDT would conduct an assessment by completing the Self-Administration Safety Screen to determine whether the resident is capable of safely self-administering medications. The DON stated that Resident 160 had not been assessed for self-administration of medication, and there was no Self-Administration Safety Screen form found in Resident's 160's medical record. During a concurrent observation and interview with Resident 160 on 5/7/2026 at 11:52 a.m. in Resident 160's room with Registered Nurse (RN) 1, observed a box of Neosporin (over-the-counter triple antibiotic ointment used to prevent infections in minor cuts, scrapes, and burns) on Resident 160's bed tray table. Resident 160 stated she applies the Neosporin ointment on sores she would get and pointed to a marked redness on the left side of her face, near her right ear. When asked of other areas she applies the Neosporin, Resident 160 raised her voice and stated I don't know where else I put it on, but I have many referring to multiple sores where she uses the ointment. Resident 160 could not specify how often she applies Neosporin or all the locations she applies Neosporin, only that she applies it to prevent her sores from becoming infected. During a review of Resident's 160's ?Treatment Administration Record (TAR), dated April 2026, the TAR indicated licensed staff's initials in the box for everyday of the month for day, evening, and night for May have Neosporin at the bedside per patient's request, every shift for Neosporin use. During a review of Resident's 160's TAR, dated May 2026, the TAR indicated licensed staff's initials in the box for everyday from 5/1/2026-5/6/2027 for day, evening, and night for May have Neosporin at the bedside per patient's request, every shift for Neosporin use. During a review of the facility's policy and procedure (P&P) titled, Self-Administration of Medications last reviewed 1/26/2026, the P&P indicated, Residents have the right to self-administer medications if the interdisciplinary team (IDT) has determined that it is clinically (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	appropriate and safe for the resident to do so. As part of the evaluation comprehensive assessment, the IDT assesses each resident's cognitive and physical abilities to determine whether self-administering medication is safe and clinically appropriate for the resident.If is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and the care plan. The decision that a resident can safely administer medications is re-assessed periodically based on changes in the resident's medical and/or decision-making status.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that a call light (a device used by a patient to signal his or her need for assistance from a professional staff) was within reach for two of seven sampled residents (Resident 60, Resident 144) investigated under the environment task. ˆ This deficient practice had the potential to result in Resident 60 and Resident 144 not being able to call for facility staff assistance and delay in the provision of necessary care and services which could negatively affect the residents' comfort and well-being.ˆ Findings:ˆ a. During a review of Resident 60's admission Record (the front page of the chart that contains a summary of basic information about the resident), the admission Record indicated the facility originally admitted Resident 60 on 1/30/2024, re-admitted on [DATE], with diagnoses that included chronic obstructive pulmonary disease (COPDˆˆlung disease that causes shortness of breathˆand narrowing of theˆairways), acute (sudden onset) respiratory failure (a condition where the lungs cannot release enough oxygen into the blood)ˆ with hypoxia (an insufficient amount of oxygen in your body tissues) and need for assistance with personal care.ˆ During a review of Resident 60's Minimum Data Set (MDS - a resident assessment tool) dated 2/6/2026, the MDS indicated Resident 60 usually makes herself understood and usually understand others. The MDS indicated Resident 60 had severely impaired cognitive (relating to or involving the processes of thinking and reasoning) function. The MDS further indicated Resident 60 was dependent (helper does all the effort) with toileting hygiene, personal hygiene, shower/bathe self, required partial/moderate assistance (helper does less than half the work) with oral hygiene, and required supervision or touching assistance (helper sets up or cleans up) with eating.ˆ During an observation on 5/4/2026 at 11:16 a.m., in Resident 60's room, observed Resident 60 in bed with the call light on the floor on the left side of Resident 60's bed. During an interview on 5/4/2026 at 11:19 p.m. with Certified Nursing Assistant 1 (CNA 1) in Resident 60's room, CNA 1 stated that Resident 60's call light was on the floor. CNA 1 stated she did not use the clip to keep the call light in place which caused the call light to fall off the bed, making the call light out of reach for Resident 60. CNA 1 stated it is important that the call light is within reach for the resident to alert staff when Resident 60 needs assistance. CNA 1 stated that if call light is not within reach, Resident 60 would not be able to get the assistance the resident needs. During a review of Resident 60's care plan (a document that outlines a resi ˆ dent's healthcare needs, goals, and the interventions planned to achieve those goals) titled, [Resident 60] At risk for falls related to generalized weakness/decreased physical activity, side effects of medications, COPD. last revised 2/19/2026, the care plan indicated an intervention to ensure call light within reach and encourage the resident to use it for assistance as needed. b. During a review of Resident 144's admission Record, the admission Record indicated the facility originally admitted Resident 144 on 7/14/2022 and re-admitted on [DATE], with diagnoses that included hemiplegia (loss of muscle function and voluntary movement) and hemiparesis (partial weakness or reduced control of one side of the body) following cerebral infarction (ischemic stroke, which is caused by a blockage of blood flow to the brain) affecting left non-dominant side, type 2 diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing), peripheral vascular disease (PVD - a condition that results in poor circulation of the blood) During a review of Resident 144's MDS dated [DATE], the MDS indicated Resident 144 was able to make self-understood and understand others. The MDS indicated Resident 144 had moderately impaired cognition. The MDS further indicated Resident 144 was dependent (helper does all the effort) with toileting hygiene, lower body dressing, required substantial/maximal assistance (helper does more than half the effort) with shower/bathe self, required partial/moderate assistance with oral hygiene and personal hygiene, and required supervision or touching assistance (helper sets up or cleans up) with eating.ˆ During a concurrent observation and interview on 5/4/2026 at 11:46 a.m., observed Resident 144 lying in bed with the call light dangling off Resident 144's right (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	side upper bed rail. Resident 144 stated he uses the call light to alert facility staff when needing assistance. Resident 144 stated he did not know where his call light was. During an interview on 5/4/2026 at 11:56 a.m. with Care Partner 1 (CP 1) at Resident 144's room, CP 1 stated Resident 144's call light was dangling from Resident 144's bed where Resident 144 could not reach it. CP 1 stated that the call light should always be within Resident 144's reach for the resident to be able to call for assistance as needed. CP 1 stated added that not having call light within reach of the resident could potentially result in a resident fall. During a review of Resident 144's care plan titled, [Resident 144] At risk for falls related to generalized weakness/decreased physical activity, side effects of medications. last revised 4/23/2026, the care plan indicated an intervention to ensure call light within reach and encourage the resident to use it for assistance as needed. During an interview on 5/7/2026 at 10:39 a.m. with the Director of Nursing (DON), the DON stated that the call light should always be placed within reach of the residents to ensure they can request assistance as needed. The DON stated that failing to keep the call light accessible may delay the provision of care and services to residents. The DON further stated that when residents do not have access to the call light, there is an increased risk of falls if the resident attempts to get out of bed without assistance if resident has limited mobility. During a review of the facility's policy and procedure (P&P) titled, Answering the Call Light last reviewed 1/26/2026, the P&P indicated, Ensure that the call light is accessible to the resident while in bed, from the toilet, from the shower or bathing facility and from the floor.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one out of four sampled resident rooms (Resident 105 and 174's shared room) was within a comfortable temperature range of 71 degrees Fahrenheit (ˆ F) to 81 ˆ F. This deficient practice placed Residents 105 and 174 at risk for being uncomfortable due to the low temperature in the facility. Findings: a. During a review of Resident 105's admission Record, the admission Record indicated the facility admitted the resident on 4/1/2026 with diagnoses including, but not limited to, fracture of the left humerus (upper arm bone), history of falling, and dementia (a progressive state of decline in mental abilities). During a review of Resident 105's Physician Progress Note, dated 4/2/2026, the progress note indicated the resident was not capable of making her own medical decisions. During a review of Resident 105's Minimum Data Set (MDS - a resident assessment tool), dated 4/7/2026, the MDS indicated Resident 105 had severe cognitive impairment (trouble with thinking, learning, and remembering clearly). The MDS indicated Resident 105 was dependent (helper does all of the effort) on staff for most activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). b. During a review of Resident 174's admission Record, the admission Record indicated the facility admitted the resident on 4/23/2026 with diagnoses including, but not limited to, acute (severe, sudden onset) and chronic (long-term) respiratory failure (a condition where the lungs cannot release enough oxygen into the blood) and difficulty in walking. During a review of Resident 174's Physician Progress Note, dated 4/24/2026, the progress note indicated the resident was capable of making her own medical decisions. During a review of Resident 174's MDS, dated [DATE], the MDS indicated Resident 17 was cognitively intact (able to think, learn, and remember clearly). The MDS indicated Resident 174 required substantial assistance (helper does more than half of the effort) with most ADLs. During an interview on 5/4/2026 at 12:11 p.m. with Resident 174 and Resident 174's family member (FM 2) at Resident 174's bedside, Resident 174 stated it gets too cold in the facility especially at night. FM 2 stated he brought extra blankets from home for Resident 174, but she tells him it is still too cold. During a concurrent observation and interview on 5/7/2026 at 8:37 a.m. with the Director of Maintenance (DOM) in the hallway outside of Resident 105 and Resident 174's shared room, the DOM took the temperature of the room with an infrared thermometer (a temperature gun, a device that measures an object's temperature from a distance by detecting infrared radiation emitted by the object). The temperature in the room was 70 ˆ F. During a concurrent observation and interview on 5/7/2026 at 8:56 a.m., the DOM took a second temperature in Resident 105 and Resident 176's shared room with an infrared thermometer. The temperature in the room was 68 ˆ F. The DOM stated their goal is to keep each resident room between 73-76 ˆ F for the residents' comfort unless they prefer the temperature to be at something different. During a concurrent interview and record review on 5/7/2026 at 1:00 p.m. with the Director of Nursing (DON), the DON stated the facility should be kept at a comfortable temperature for the residents to make sure they provide them a homelike environment. The DON stated if it's too cold it won't be comfortable for the resident. During a review of the facility's Policy and Procedure (P&P) titled, Homelike Environment, last reviewed on 1/21/2026, the P&P indicated residents are provided with a safe, clean, comfortable, and homelike environment. The P&P further indicated the facility staff, and management maximizes, to the extent possible, the characteristics of the facilty that reflect a personalized, homelike setting including a comfortable and safe temperature of 71-81 ˆ F.

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a Licensed Vocational Nurse (LVN 5) maintained a current CPR (cardio-pulmonary resuscitation - an emergency, life-saving technique performed when someone's breathing or heartbeat has stopped) certification from a CPR provider whose training includes a hands-on session in accordance with accepted national standards for one of five staff members investigated in the staffing facility task. The deficient practice had the potential for staff to perform substandard life-saving measures to residents which could result in negative outcomes including death.Findings: During an employee file audit of LVN 5 on [DATE] at 11:03 a.m. with Care Partner 1 (CP 1) and the Infection Preventionist (IP), the employee file contained a certificate of completion for CPR training through CPR Training Provider 1 (CPRTP 1). The IP stated they offer CPR training at the facility but if an employee takes an outside course they will accept it. CP 1 stated she was unsure if the CPR training LVN 5 completed included a hands-on component to it. During an interview on [DATE] at 11:48 a.m. with LVN 5, LVN 5 stated the CPR training she received was through a website recommended by a past instructor. LVN 5 stated the training consisted of online videos and a test on the website that asked questions about the online content. LVN 5 stated there was not an in-person hands-on component to the training. During an interview on [DATE] at 1:00 p.m. with the Director of Nursing (DON), the DON stated CPR training should have a hands-on component to ensure staff knows how to do CPR correctly. The DON stated if a staff member does not know how to do CPR correctly there is a risk of harming the resident or death. During a review of CPRTP 1's website, dated 2026, the webpage titled Support indicated: No, we do not offer hands-on training. During a review of the facility's Policy and Procedure (P&P) titled, Emergency Procedure - Cardiopulmonary Resuscitation and Basic Life Support, last reviewed on [DATE], the P&P indicated preparation for the administration of CPR during an emergency consists of the following facility practices: Maintain personnel CPR certification for healthcare providers through a CPR provider whose training includes hands-on practice an skills assessment, either in a physical or virtual instructor-led setting, in accordance with accepted national standards.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, and record review the facility failed to ensure residents received care consistent with professional standards of practice to prevent pressure injuries (PI/PU injuries to the skin and underlying tissue resulting from prolonged pressure) by failing to ensure the bilateral heel protectors were on and the heels were floated (when the lower leg is elevated with a pillow, leaving the heel floating to air) according to the doctors order for one of three sampled residents (Resident 7) investigated under pressure injuries. This deficient practice had the potential for the worsening of or the development of PI/Pus in Resident 7. Findings: During a review of Resident 7's admission Record, the admission Record indicated the facility initially admitted Resident 7 on 3/18/2026 with diagnoses that included type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), falls and dysphagia (difficulty swallowing). During a review of Resident 7's Minimum Data Set (MDS, a resident assessment tool), dated 5/5/2026, indicated Resident 7 was only sometimes understood by others and only sometimes understands others. The MDS further indicated Resident 7 required setup assistance (helper sets up or cleans up for the resident) for activities such as eating and oral hygiene and substantial assistance (when helper does more thana half the effort) for toileting, bathing, and lower body dressing. During a review of Resident 69's Physician's Orders, active as of 5/7/2026, the Physician's Orders indicated an order dated 4/26/2026 to float bilateral heels when in bed with heel protectors and/or wedge to offload pressure. During a concurrent observation and interview on 5/4/2026 at 9:33 a.m. with the Licensed Vocational Nurse (LVN 7) in Resident 7's room, LVN 7 looked at Resident 7's feet and stated only the right heel had a heel protector and neither of her feet were floated. During a concurrent interview and record review on 5/4/2026 ay 9:46 a.m. with LVN 7, LVN 7 reviewed Resident 7's physician's orders and stated both of Resident 7's heel should have been floated with heel protectors to prevent further skin breakdown. During an interview on 5/7/2026 at 1:37 p.m. with the Director of Nursing (DON), the DON stated Resident 7's heel must be floated and have protectors on at all times while in bed. The DON stated licensed nurses and certified nurse assistants (CNAs) work together to prevent worsening of Resident 7s heel pressure injury. During a review of the facility's Policy and Procedure, (P&P) titled Skin and Wound Monitoring and Management last reviewed 1/21/2026, the P&P indicated to prevent pressure injuries to residents by repositioning and using pressure relieving /reducing and redistributing devices including but not limited to pressure relieving mattresses, wedges and pillows.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. Based on observation, interview, and record review, the facility failed to ensure the intravenous (IV - into the vein) insertion site (site on the body where IV is inserted through the skin) and the label indicating the date of insertion were visible and not covered with white tape for one of one sampled resident (Resident 172). This deficient practice had the potential to delay the identification of complications, including pain/redness, and infection at the IV insertion site. Findings: During a review of Resident 172's admission Record, the admission Record indicated the facility admitted Resident 172 on 4/26/2026 with diagnoses including urinary tract infection (UTI- an infection in the bladder/urinary tract), bacteremia (the presence of bacteria in the bloodstream) and dementia (a progressive state of decline in mental abilities) During a review of Resident 172's History and Physical (H&P) the H&P indicated Resident 172 did not have the capacity to make his own medical decisions. During a review of Resident 172's Minimum Data Set (MDS- a resident assessment tool), dated 5/3/2026, the MDS indicated Resident 172 required substantial assistance (helper does more than half the effort) for activities such as eating. During a review of Resident 172's At Risk for IV Therapy Complications Care Plan (CP) initiated on 4/30/2026, the CP indicated the following interventions: -monitor and document signs and symptoms of infection at the site: drainage, inflammation, swelling, redness, warmth and notify physician. -monitor and document signs and symptoms of leaking at the IV site, edema (swelling caused by excess fluid trapped in your body's tissues) at the insertions site. During a review of Resident 172's Order Summary Report, active as of 5/7/2026, the Order Summary Report indicated an order dated 4/26/2026 to monitor IV site every shift for signs and symptoms of complications. During an observation on 5/4/2026 at 8:40 a.m. in Resident 172's room, Resident 172 was sitting up in his wheelchair watching television. Observed Resident 172 with white tape wrapped around his left antecubital (AC - the crook of the elbow or the inside bend of the arm). During a concurrent observation and interview 5/4/2026 at 8:46 a.m. in Resident 172's room with Registered Nurse 2 (RN 2), RN 2 looked at Resident 172's left arm and stated that the white tape was covering the IV insertion site. RN 2 stated that the IV insertion site and the label indicating the date of insertion could not be observed because they were covered with white tape. RN 2 stated she could not fully implement the order to monitor the IV site because it was not visible and any complications could have the potential to be missed. RN 2 stated IVs should be changed every seven days, and she could not visualize the date of insertion to validate when the IV was inserted. During an interview on 5/7/2026 at 11:50 a.m. with the Director of Nursing (DON), the DON stated the insertion site of an IV must be visible to monitor for complications. The DON stated the nurses should have never added that much white tape, instead if the dressing was loose, reinforce or change the dressing instead. The DON stated IVs should not be kept in longer than seven days. During a review of the facility's Policy and Procedure, (P&P) titled Peripheral and Midline IV Dressing Changes last reviewed 1/21/2026, the P&P indicated the purpose of the policy is to prevent complications associated with IV therapy. The P&P further indicated to document the date and time.

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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. Based on observation, interview and record review, the facility failed to ensure a resident's hand-held nebulizer (a device that turns liquid medicine into mist you breathe in) and tubing was dated for one of one sampled resident (Resident 172) investigated under respiratory care area. This deficient practice had the potential to result in contamination of the resident's care equipment and risk of transmission of bacteria that can lead to infection. Findings: During a review of Resident 172's admission Record, the admission Record indicated the facility admitted Resident 172 to the facility on 4/26/2026 with diagnoses including urinary tract infection (UTI- an infection in the bladder/urinary tract), bacteremia (the presence of bacteria in the bloodstream) and dementia (a progressive state of decline in mental abilities) During a review of Resident 172's History and Physical (H&P) the H&P indicated Resident 172 did not have the capacity to make his own medical decisions. During a review of Resident 172's Minimum Data Set (MDS, a resident assessment tool), dated 5/3/2026, the MDS indicated the Resident 172 required substantial assistance (helper does more than half the effort) for activities such as eating. During a review of Resident 172's Order Summary Report, active as of 5/7/2026, the Order Summary Report indicated an order dated 4/26/2026 for: - Ipratropium-Albuterol Inhalation Solution (medication to prevent and treat breathing difficulties). 1 (one) unit inhaled orally via nebulizer every 6 (six) hours as needed for SOB (shortness of breath) During a concurrent observation and interview 5/4/2026 at 8:51 a.m. in Resident 172's room with Registered Nurse (RN 2), Resident 172 was sitting up in his wheelchair watching television. Observed a hand-held nebulizer on top of Resident 172's bedside table. RN 2 stated the hand-held nebulizer did not have a label indicating the date it was last changed. RN 2 stated that any oxygen tubing or hand-held nebulizer must be labeled with the date and time it was last changed so staff would know when the hand-held nebulizer and tubing are due for a change to prevent the growth of bacteria and cross contamination. During an interview on 5/7/2026 at 11:57 a.m. with the Director of Nursing (DON), the DON stated all medical devices such as nasal cannulas, nebulizers and tubing must be dated with the date it was changed for other staff members to know when it was last changed and to prevent bacteria growth. The DON stated Resident 172's hand-held nebulizer should have had a label indicating the date it was last changed. During a review of the facility`s policy and procedure titled Oxygen Administration, last reviewed on 1/21/2026, the policy indicated that the purpose of this procedure is to provide guidelines for safe oxygen administration.review the physician`s orders or facility protocol for oxygen administration. The P&P further indicated the tubing must be changed every 7 (seven) days and the date and time changed must be documented.

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	555822	A. Building B. Wing	05/07/2026

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. Based on observation, interview, and record review the facility failed to maintain an environment free from accident hazards for one of seven residents (Resident 22) investigated for accidents when there was no informed consent obtained prior to the installation of left and right upper side rails (adjustable rigid plastic or metal bars attached to the bed that may be positioned in various locations on the bed; upper or lower, either or both sides). This deficient practice had the potential to result in adverse effects from the side rails including restriction of physical movement and entrapment (becoming caught between the rails and the mattress). Findings: During a review of Resident 22's admission Record, the admission Record indicated the facility admitted the resident on 3/20/2025 with diagnoses including, but not limited to, acute (severe, sudden onset) and chronic (long-term) respiratory failure (a condition where the lungs cannot release enough oxygen into the blood), dementia (a progressive state of decline in mental abilities), and difficulty in walking. During a review of Resident 22's History and Physicals (H&Ps), dated 5/6/2026 and 3/25/2025, the H&Ps both indicated the resident was not capable of making his own medical decisions. During a review of Resident 22's Minimum Data Set (MDS - a resident assessment tool), dated 3/24/2026, the MDS indicated Resident 22 had severe cognitive impairment (trouble with thinking, learning, and remembering clearly). The MDS indicated Resident 22 required substantial assistance (helper does more than half of the effort) with showering, Resident 22 required partial assistance (helper does less than half of the effort) with toileting, lower body dressing, and putting on and taking off footwear, and Resident 22 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying) with oral hygiene, upper body dressing, and personal hygiene. During a review of Resident 22's Order Summary Report, the Order Summary Report indicated an active order for the following: Safety: Upper bilateral Quarter - 1/4 Rail.for increased mobility and transfers to promote resident independence and use as an enabler, dated 2/3/2026. During a review of Resident 22's care plan (a document that outlines a resident's healthcare needs, goals, and the interventions planned to achieve those goals) titled, [Resident 22] is at risk for impaired bed mobility., dated 6/25/2025, the care plan indicated the following interventions: Provide education to the resident/resident representative on the positioning bar/rail(s) intended purpose and potential risk. The care plan further indicated: Obtain informed consent from resident/resident representative for use of positioning bar/rail(s) to assist with moving within the bed, getting in and out of bed. During a concurrent interview and record review on 5/5/2026 at 3:51 p.m. with the Assistant Director of Nursing (ADON), Resident 22's Positioning Bar/Rail and Informed Consent, dated 3/20/2025, indicated Resident 22 was the individual educated on the risks and benefits of the side rails and did not indicate informed consent was obtained. The ADON stated Resident 22 has impaired cognition and she was not sure if he could have given consent at that time. The ADON stated there was no other documentation that an informed consent was obtained in the resident's side rail assessments. The ADON stated informed consent should be obtained so the resident and family are fully informed of the plan of care and the potential risks which could include entrapment or bumping himself on the side rail which could cause bruising or skin tears (traumatic wounds caused by friction when the upper layer of the skin becomes torn from the underlying layers). During an observation on 5/5/2026 at 4:01 p.m. with the ADON at Resident 22's bedside, Resident 22 was in bed, and two quarter-length side rails were attached and raised on the upper part of the resident's bed. During a concurrent interview and record review on 5/7/2026 at 1:00 p.m. with the Director of Nursing (DON), Resident 22's Positioning Bar/Rail and Informed Consent, dated 3/20/2025, was reviewed. The DON stated the resident was not fully oriented and the resident's family member (FM 3), who is his representative, should have been notified of the side rails and given education about the potential risks and benefits. The DON stated (continued on next page)

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the informed consent for the side rails should have been obtained from the resident's family member. The DON stated the resident, and family should be aware there are potential risks from side rails including injury, fractures, and entrapment. During a review of the facility's Policy and Procedure (P&P) titled, Bed Safety and Bed Rails, last reviewed on 1/21/2026, the P&P indicated: Before using bed rails for any reason, the staff shall inform the resident or representative about the benefits and potential hazards associated with bed rails and obtain informed consent.