DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POC accepted on 08/27/19

PRINTED: 08/14/2019
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056133 | A. BUILDING 01 - MAIN BUILDING 01 05373<br>B. WING _____ | 07/31/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WEST HILLS HEALTH & REHAB CENTER | 7940 TOPANGA CANYON BLVD.<br>CANOGA PARK, CA 91304 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K 000 | INITIAL COMMENTS<br><br>This facility was surveyed under 42 CFR Part 483.70 (a) Life Safety Code NFPA 101, 2012 Edition, Chapter 19 Existing Health Care Occupancies, and other applicable codes.<br><br>The following represents the findings of the Department of Public Health during a Life Safety Code Survey.<br><br>Representing the Department of Public Health: Surveyor ID No. 05373, REHS, HFE<br><br>Highest S/S =E<br>Census = 131 | K 000 | PREPARATION AND/OR EXECUTION OF THIS PLAN OF CORRECTION DOES NOT CONSTITUTE ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH, THE FACTS ALLEGED, OR CONCLUSION SET FORTH IN THIS STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISION OF FEDERAL AND STATE LAW.<br><br>THIS PLAN OF CORRECTION CONSTITUTES THE FACILITY'S CREDIBLE ALLEGATION OF COMPLIANCE. | |
| K 222<br>SS=E | Egress Doors<br>CFR(s): NFPA 101<br><br>Egress Doors<br>Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements:<br>CLINICAL NEEDS OR SECURITY THREAT LOCKING<br>Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times.<br>18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6<br>SPECIAL NEEDS LOCKING ARRANGEMENTS<br>Where special locking arrangements for the safety needs of the patient are used, all of the | K 222 | K222 – SS=E<br><br>A. 1. The deadbolt lock mechanism to the two public restrooms' door located near Nursing Station 1 was replaced with a single action mechanism on 7/31/19.<br><br>2019 AUG 23 AM 11:06 | 8/20/2019 |

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

Mark J. Donohue — Administrator — 8/22/19

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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056133 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 07/31/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WEST HILLS HEALTH & REHAB CENTER | 7940 TOPANGA CANYON BLVD.<br>CANOGA PARK, CA 91304 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K 222 | Continued From page 1<br>Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation.<br>18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4<br>DELAYED-EGRESS LOCKING ARRANGEMENTS<br>Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system.<br>18.2.2.2.4, 19.2.2.2.4<br>ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS<br>Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted.<br>18.2.2.2.4, 19.2.2.2.4<br>ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS<br>Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system.<br>18.2.2.2.4, 19.2.2.2.4<br>This REQUIREMENT is not met as evidenced by: | K 222 | 2. The double action release door lock mechanism on the door to the activity room was replaced with a single action mechanism on 7/31/19.<br>3. The dead bolt lock on the door to the rehab storage room was replaced with a single action mechanism on 7/31/19.<br><br>B. 1. The maintenance supervisor checked all door locks throughout the facility to ensure all had single action mechanisms.<br><br>C. The maintenance staff will monitor this corrective action during daily rounds.<br><br>D. All trends will be shared with QAPI Committee for further recommendations and follow ups. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056133 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 07/31/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WEST HILLS HEALTH & REHAB CENTER | 7940 TOPANGA CANYON BLVD.<br>CANOGA PARK, CA 91304 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K 222 | Continued From page 2<br>NFPA 101, Life Safety Code, 2012 Edition<br>19.2.2.2 Doors.<br>19.2.2.2.1 Doors complying with 7.2.1 shall be permitted.<br>7.2.1.5.1 Door leaves shall be arranged to be opened readily from the egress side whenever the building is occupied.<br>7.2.1.5.10* A latch or other fastening device on a door leaf shall be provided with a releasing device that has an obvious method of operation and that is readily operated under all lighting conditions.<br>7.2.1.5.10.2 The releasing mechanism shall open the door leaf with not more than one releasing operation, unless otherwise specified in 7.2.1.5.10.3, 7.2.1.5.10.4, or 7.2.1.5.10.6.<br><br>Based on observation and interview, the facility failed to ensure the doors to the bathrooms, the rehab storage, and activity room, were not equipped with dead bolt and lever and more than one action release mechanism. Doors used for egress that open easily and immediately may allow occupants to evacuate the building safely and immediately in the event of a fire emergency. In the event of a need to evacuate the building, locks and latches that obstruct the path of egress may prevent or delay evacuation.<br><br>The deficient practice affected three of five smoke compartments.<br><br>Findings:<br><br>On July 30, 2019, from 9:45 to 11:45 a.m., during a tour of the facility in the presence of the maintenance director, the following was noted:<br><br>a. There was a dead bolt lock mechanism to the two public bathroom's door located near the | K 222 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056133 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 07/31/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WEST HILLS HEALTH & REHAB CENTER | 7940 TOPANGA CANYON BLVD.<br>CANOGA PARK, CA 91304 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K 222 | Continued From page 3<br>Nursing Station I.<br><br>b. There was a double action release door lock mechanism on the door to the activity room.<br><br>c. There was a dead bolt lock on the door to the rehab storage room.<br><br>The maintenance director confirmed the findings and acknowledged the need to change them. | K 222 | | |
| K 271 SS=D | Discharge from Exits<br>CFR(s): NFPA 101<br><br>Discharge from Exits<br>Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface.<br>18.2.7, 19.2.7<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and review of the evacuation plan, the facility failed to maintain the egress pathways free of obstructions. In the event of smoke and/or fire, an unobstructed means of egress is essential in prompt evacuation of residents and staff as well as facilitating easy access into the facility by the fire department in response to an emergency. The deficient practice affected one of nine exits to the parking lot.<br><br>Findings:<br><br>On July 30, 2019, during an observation of the exterior of the building, the following was noted: | K 271 | K271 – SS=D<br><br>A. The linen hampers were removed at time of both observations from the northeast exit door area. An in-service was given to all staff on 08/19/2019 regarding not blocking exit doors with any equipment.<br><br>B. The Director of Staff Development checked all exit doors and did not find any other exits being blocked by equipment.<br><br>C. All Department managers were instructed to observe the exit doors for any items blocking the path of evacuation during daily rounds.<br><br>D. All trends will be shared with the QAPI Committee for further recommendations and follow up. | 8/20/2019 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056133 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 07/31/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WEST HILLS HEALTH & REHAB CENTER | 7940 TOPANGA CANYON BLVD.<br>CANOGA PARK, CA 91304 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K 271 | Continued From page 4<br><br>a. At 7:30 a.m., the evaluator observed ten double hampers parked right outside of the north-east exit door on the path of evacuation in front of the main exit door leading to the parking. One side of the door was completely blocked by the hampers.<br><br>b. At 12:20 p.m., the evaluator observed six double hampers parked right outside of the north-east exit door on the path of evacuation in front of the main exit door leading to the parking.<br><br>The maintenance director confirmed that the door was the main exit to the parking and the path of evacuation needed to be unobstructed.<br><br>A review of the evacuation plan indicated that this was the exit to the parking lot. | K 271 | | |
| K 324 SS=E | Cooking Facilities<br>CFR(s): NFPA 101<br><br>Cooking Facilities<br>Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless:<br>* residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2<br>* cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or<br>* cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. | K 324 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056133 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 07/31/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WEST HILLS HEALTH & REHAB CENTER | 7940 TOPANGA CANYON BLVD.<br>CANOGA PARK, CA 91304 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K 324 | Continued From page 5<br>Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor.<br>18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2<br><br>This REQUIREMENT is not met as evidenced by:<br>NFPA 101, Life Safety Code, 2012 Edition<br>19.3.2.5 Cooking Facilities.<br>19.3.2.5.1 Cooking facilities shall be protected in accordance with 9.2.3, unless otherwise permitted by 19.3.2.5.2, 19.3.2.5.3, or 19.3.2.5.4.<br>9.2.3 Commercial Cooking Equipment.<br>Commercial cooking equipment shall be in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless such installations are approved existing installations, which shall be permitted to be continued in service.<br><br>NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 2011 Edition<br><br>11.2 Inspection, Testing, and Maintenance of Fire-Extinguishing Systems.<br>11.2.1* Maintenance of the fire-extinguishing systems and listed exhaust hoods containing a constant or fire-activated water system that is listed to extinguish a fire in the grease removal devices, hood exhaust plenums, and exhaust ducts shall be made by properly trained, qualified, and certified person(s) acceptable to the authority | K 324 | K324- SS=E<br><br>A. The administrator contacted Flue Steam, the company that performs the kitchen exhaust system and tire suppression service to provide more detailed documentation on service provided.<br><br>B. The entire facility would potentially be affected by this deficient practice.<br><br>C. The Administrator will review the documentation provided by the Flue Steam Company at time of service to ensure compliance with this corrective action.<br><br>D. All trends will be shared with the QAPI Committee for further recommendation and follow up. | 8/20/2019 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056133 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 07/31/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WEST HILLS HEALTH & REHAB CENTER | 7940 TOPANGA CANYON BLVD.<br>CANOGA PARK, CA 91304 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K 324 | Continued From page 6<br>having jurisdiction at least every 6 months.<br><br>Based on interview and record review, the facility failed to ensure the cooking equipment was protected in accordance with NFPA 96, by failing to provide documented evidence that an inspection, servicing and grease removal of the listed exhaust system was conducted every six months by a qualified person. The six months service of the kitchen listed exhaust system helps prevent accumulation of grease and other fire active materials from building up in the exhaust system, helping to decrease the potential for a fire hazard in the hood and flue.<br><br>The deficient practice affected one of five smoke compartments.<br><br>Findings:<br><br>On July 30, 2019, during an interview and record review with the maintenance director and the dietary supervisor, it was noted that the kitchen exhaust system service and cleaning was conducted on September 06, 2018 and March 01, 2019. For both kitchen exhaust system service and exhaust system professional cleaning, the documentation provided consisted of a bill indicating how much the vendor was charging for the provided service rather than itemizing what service was provided.<br><br>The maintenance director confirmed the findings. | K 324 | | |
| K 351 SS=D | Sprinkler System - Installation<br>CFR(s): NFPA 101<br><br>Spinkler System - Installation<br>2012 EXISTING | K 351 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056133 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 07/31/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WEST HILLS HEALTH & REHAB CENTER | 7940 TOPANGA CANYON BLVD.<br>CANOGA PARK, CA 91304 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K 351 | Continued From page 7<br>Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.<br>In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers.<br>In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems.<br>19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1)<br>This REQUIREMENT is not met as evidenced by:<br>NFPA 13 5-5.5.3 Obstructions that prevent sprinkler discharge from reaching the hazard. Continuous or non-continuous obstructions that interrupt the water discharge in a horizontal plane more than 18 inches (457 mm) below the sprinkler deflector in a manner to limit the distribution from reaching the protected hazard shall comply with 5-5.5.3.<br><br>Based on observation and interview, the facility failed to maintain an 18 inches clearance from the sprinkler head deflector in the activity storage room. In the event of a fire, a clear and unobstructed water discharge from the sprinkler head deflector to the top of the stored items where 18 inches of clearance is maintained will ensure that water from the sprinkler head will disperse and reach the protected hazard.<br><br>The deficient practice affected one of five smoke | K 351 | K351-SS=D<br><br>A. The bed paddings were removed from top shelves of linen closet near room 43 at the time of observation.<br><br>B. The maintenance supervisor checked all the linen closets throughout the facility to ensure that there was an 18 inch clearance from the sprinkler heads.<br><br>C. All department managers were instructed to observe the 18 inch clearance from the sprinkler heads in all linen closets.<br><br>D. All trends will be shared with the QAPI Committee for further recommendations and follow up. | 8/20/2019 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056133 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 07/31/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WEST HILLS HEALTH & REHAB CENTER | 7940 TOPANGA CANYON BLVD.<br>CANOGA PARK, CA 91304 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K 351 | Continued From page 8<br>compartments.<br><br>Findings:<br><br>On July 30, 2019, during the tour of the facility accompanied by the maintenance director, several bags of bed paddings were observed stored on the top shelves of the linen closet near Room 43. The bags were about eight inches below the sprinkler deflector in the room.<br><br>During an interview, the maintenance director stated that there should be 18 inches clearance from the sprinkler head deflector and he would have the items removed to prevent the obstructions under the sprinkler deflector. | K 351 | | |
| K 918 SS=E | Electrical Systems - Essential Electric Syste<br>CFR(s): NFPA 101<br><br>Electrical Systems - Essential Electric System Maintenance and Testing<br>The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.<br>Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of | K 918 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056133 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 07/31/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WEST HILLS HEALTH & REHAB CENTER | 7940 TOPANGA CANYON BLVD.<br>CANOGA PARK, CA 91304 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K 918 | Continued From page 9<br>stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.<br>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)<br>This REQUIREMENT is not met as evidenced by:<br>NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition.<br>Chapter 8 Routine Maintenance and Operational Testing<br>8.3.7.1 Maintenance of lead-acid batteries shall include the monthly testing and recording of electrolyte specific gravity. Battery conductance testing shall be permitted in lieu of the testing of specific gravity when applicable or warranted.<br><br>Based on record review and interview, the facility failed to ensure the emergency generator weekly inspection included the specific gravity reading and/or the conductance test. The deficient practice could result in a generator malfunction due to a battery failure and affected the entire facility.<br><br>Findings:<br><br>On July 30, 2019, at 2:30 p.m., during a review of the maintenance test log book it was noted that | K 918 | K918 – SS=E<br><br>A. The Maintenance Supervisor revised the Maintenance Test Log Book to include documentation to indicate the specific gravity reading of the storage batteries on 7/31/19.<br><br>B. All residents have the potential to be affected by this deficient practice.<br><br>C. The Maintenance Supervisor will test the specific gravity of the storage batteries of the generator monthly to ensure compliance.<br><br>D. All trends will be shared with the QAPI Committee for further recommendation and follow up. | 8/20/2019 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056133 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 07/31/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WEST HILLS HEALTH & REHAB CENTER | 7940 TOPANGA CANYON BLVD.<br>CANOGA PARK, CA 91304 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K 918 | Continued From page 10<br>there was no documentation to indicate the specific gravity reading of the storage batteries were conducted. The weekly form did not include numeric value for specific gravity test.<br><br>During a concurrent interview with the maintenance director, he confirmed that the specific gravity test was not conducted. | K 918 | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POC acceptation 8/27/19 05373

PRINTED: 08/14/2019
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056133 | A. BUILDING _____ B. WING _____ | 07/31/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WEST HILLS HEALTH & REHAB CENTER | 7940 TOPANGA CANYON BLVD. CANOGA PARK, CA 91304 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 000 | Initial Comments<br><br>The following reflects the findings of the California Department of Public Health, during an Emergency Preparedness recertification survey. The findings are in accordance with 42 Code of Federal Regulations (CFR) 483.73, Requirement for Long Term Care (LTC) Facilities.<br><br>Representing the Department of Public Health:<br><br>Surveyor ID No. 05373, REHS, HFE<br><br>Census = 131<br><br>Scope and Severity: C | E 000 | PREPARATION AND/OR EXECUTION OF THIS PLAN OF CORRECTION DOES NOT CONSTITUTE ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH, THE FACTS ALLEGED, OR CONCLUSION SET FORTH IN THIS STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISION OF FEDERAL AND STATE LAW.<br><br>THIS PLAN OF CORRECTION CONSTITUTES THE FACILITY'S CREDIBLE ALLEGATION OF COMPLIANCE. | 8/20/2019 |
| E 007<br>SS=C | EP Program Patient Population<br>CFR(s): 483.73(a)(3)<br><br>[(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:]<br><br>(3) Address patient/client population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.**<br><br>*Note: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC, FQHC, or ESRD facilities.]<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, the facility failed to ensure the emergency preparedness plan address resident population, including but | E 007 | | |

2019 AUG 23 AM 11:06

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mark L. Donohue — TITLE: Administrator — (X6) DATE: 8/22/19

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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056133 | A. BUILDING _____ B. WING _____ | 07/31/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WEST HILLS HEALTH & REHAB CENTER | 7940 TOPANGA CANYON BLVD. CANOGA PARK, CA 91304 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 007 | Continued From page 1<br>not limited to persons at risk, the type of services and the facility's ability to provide continuity of operations including delegations of authority and succession plans. The deficient practice has the potential for at risks residents not to be provided with adequate care and treatment.<br><br>Findings:<br><br>On July 31, 2019, at 11:30 a.m., during the documentation review with the admission coordinator, it was determined that the facility failed to have an emergency preparedness plan that included resident population and at risk residents considering the type of services needed in an emergency such as residents who were receiving dialysis in the dialysis facilities. The admission coordinator confirmed the findings and stated there were three residents residing in the facility who receive dialysis in a dialysis center. The admission coordinator acknowledged the need of a plan for continuity of care for the residents who are in need of dialysis during emergency. | E 007 | E007 – SS=C<br><br>A. The facility emergency preparedness plan was reviewed and revised to include resident population and at risk residents considering the type of services needed in an emergency, such as residents receiving dialysis.<br><br>B. 3 residents were added to the plan who receive dialysis treatment.<br><br>C. During the daily stand up meeting, information will be provided on admissions who are at risk considering the type of services needed in an emergency and will be added to the plan.<br><br>D. Any trends will be shared with the QAPI Committee for further recommendations or follow up. | 8/20/2019 |
| E 015 SS=C | Subsistence Needs for Staff and Patients<br>CFR(s): 483.73(b)(1)<br><br>[(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following: | E 015 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056133 | A. BUILDING _____ B. WING _____ | 07/31/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WEST HILLS HEALTH & REHAB CENTER | 7940 TOPANGA CANYON BLVD. CANOGA PARK, CA 91304 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 015 | Continued From page 2<br>(1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following:<br>(i) Food, water, medical and pharmaceutical supplies<br>(ii) Alternate sources of energy to maintain the following:<br>(A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.<br>(B) Emergency lighting.<br>(C) Fire detection, extinguishing, and alarm systems.<br>(D) Sewage and waste disposal.<br><br>*[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures.<br>(6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following:<br>(iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following:<br>(A) Food, water, medical, and pharmaceutical supplies.<br>(B) Alternate sources of energy to maintain the following:<br>(1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.<br>(2) Emergency lighting.<br>(3) Fire detection, extinguishing, and alarm systems.<br>(C) Sewage and waste disposal.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, the facility | E 015 | E015-SS=C<br><br>A. The facility emergency preparedness plan was updated to include all subsistence needs during an emergency, including medical and pharmaceutical supplies.<br><br>B. All residents and staff have the potential to be affected by this deficient practice.<br><br>C. Nursing staff and central supply staff will be responsible for re-ordering medications and supplies to ensure adequate inventory in the event of an emergency.<br><br>D. Any trends will be shared with the QAPI Committee for further recommendations or follow up. | 8/20/2019 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056133 | A. BUILDING _____ B. WING _____ | 07/31/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WEST HILLS HEALTH & REHAB CENTER | 7940 TOPANGA CANYON BLVD. CANOGA PARK, CA 91304 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 015 | Continued From page 3<br>failed to have an emergency preparedness plan addressing the provision of subsistence needs (survival) for staff and residents whether they evacuate or shelter in place. The deficient practice has the potential for residents and staff not to receive subsistence needs in an emergency.<br><br>Findings:<br><br>On July 31, 2019, at 10:40 a.m., during a review of the documentation with the admission coordinator, it was determined that the facility's current written policy and procedure did not address the subsistence needs for residents, staff, volunteers, and individuals from the community. The subsistence need the facility failed to include was medical and pharmaceutical supplies. The admission coordinator confirmed the finding and stated that they will research the proper procedure and will include it in their policy and procedure. | E 015 | | |
| E 030 SS=C | Names and Contact Information<br>CFR(s): 483.73(c)(1)<br><br>[(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:]<br><br>(1) Names and contact information for the following:<br>(i) Staff.<br>(ii) Entities providing services under arrangement.<br>(iii) Patients' physicians<br>(iv) Other [facilities]. | E 030 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056133 | A. BUILDING _____ B. WING _____ | 07/31/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WEST HILLS HEALTH & REHAB CENTER | 7940 TOPANGA CANYON BLVD. CANOGA PARK, CA 91304 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 030 | Continued From page 4<br>(v) Volunteers.<br><br>*[For RNHCIs at §403.748(c):] The communication plan must include all of the following:<br>(1) Names and contact information for the following:<br>(i) Staff.<br>(ii) Entities providing services under arrangement.<br>(iii) Next of kin, guardian, or custodian.<br>(iv) Other RNHCIs.<br>(v) Volunteers.<br><br>*[For ASCs at §416.45(c):] The communication plan must include all of the following:<br>(1) Names and contact information for the following:<br>(i) Staff.<br>(ii) Entities providing services under arrangement.<br>(iii) Patients' physicians.<br>(iv) Volunteers.<br><br>*[For Hospices at §418.113(c):] The communication plan must include all of the following:<br>(1) Names and contact information for the following:<br>(i) Hospice employees.<br>(ii) Entities providing services under arrangement.<br>(iii) Patients' physicians.<br>(iv) Other hospices.<br><br>*[For HHAs at §484.102(c):] The communication plan must include all of the following:<br>(1) Names and contact information for the following:<br>(i) Staff.<br>(ii) Entities providing services under arrangement. | E 030 | E030-SS=C<br><br>A. The facility emergency preparedness plan was updated to include an accurate and current contact information for residents' physicians' telephone numbers.<br><br>B. All residents have the potential to be affected by this deficient practice.<br><br>C. Physician phone numbers will be updated as needed. Specifically, new physicians' phone numbers will be added to the list.<br><br>D. All trends will be shared with the QAPI Committee for further recommendations and follow up. | 8/20/2019 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056133 | A. BUILDING _____ B. WING _____ | 07/31/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WEST HILLS HEALTH & REHAB CENTER | 7940 TOPANGA CANYON BLVD. CANOGA PARK, CA 91304 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 030 | Continued From page 5<br>(iii) Patients' physicians.<br>(iv) Volunteers.<br><br>*[For OPOs at §486.360(c):] The communication plan must include all of the following:<br>(1) Names and contact information for the following:<br>(i) Staff.<br>(ii) Entities providing services under arrangement.<br>(iii) Volunteers.<br>(iv) Other OPOs.<br>(v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA).<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and the record review, the facility's communication plan failed to include names and contact information for residents' physicians. The deficient practice could delay the provision of care.<br><br>Findings:<br><br>On July 31, 2019, at 12:55 p.m., during a review of the documentation and interview with the admission coordinator, it was determined that the emergency communication plan did not include accurate and current contact information for residents' physicians telephone numbers. The admission coordinator confirmed the finding. | E 030 | | |
| E 031 SS=C | Emergency Officials Contact Information<br>CFR(s): 483.73(c)(2)<br><br>[(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include | E 031 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056133 | A. BUILDING _____ B. WING _____ | 07/31/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WEST HILLS HEALTH & REHAB CENTER | 7940 TOPANGA CANYON BLVD. CANOGA PARK, CA 91304 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 031 | Continued From page 6<br>all of the following:<br><br>(2) Contact information for the following:<br>(i) Federal, State, tribal, regional, and local emergency preparedness staff.<br>(ii) Other sources of assistance.<br><br>*[For LTC Facilities at §483.73(c):] (2) Contact information for the following:<br>(i) Federal, State, tribal, regional, or local emergency preparedness staff.<br>(ii) The State Licensing and Certification Agency.<br>(iii) The Office of the State Long-Term Care Ombudsman.<br>(iv) Other sources of assistance.<br><br>*[For ICF/IIDs at §483.475(c):] (2) Contact information for the following:<br>(i) Federal, State, tribal, regional, and local emergency preparedness staff.<br>(ii) Other sources of assistance.<br>(iii) The State Licensing and Certification Agency.<br>(iv) The State Protection and Advocacy Agency.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, the facility failed to maintain an emergency preparedness communication plan to include the proper State agencies. The facility's emergency preparedness plan did not have the name and telephone number for the State ombudsman's office. The lack of this official contact information could delay or halt any care and services to the residents, during an emergency.<br><br>Findings:<br><br>On July 31, 2018, at 12:30 p.m., a review of the facility's emergency preparedness documentation | E 031 | E031 – SS=C<br><br>A. The facility emergency preparedness plan was updated to include the State Ombudsman's office and telephone number.<br><br>B. All residents have the potential to be affected by this deficient practice.<br><br>C. Any changes in the Ombudsman's address or phone number will be changed in the emergency preparedness plan immediately. Plan will be reviewed annually.<br><br>D. All trends will be shared with the QAPI Committee for further recommendations and follow up. | 8/20/2019 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056133 | A. BUILDING _____ B. WING _____ | 07/31/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WEST HILLS HEALTH & REHAB CENTER | 7940 TOPANGA CANYON BLVD. CANOGA PARK, CA 91304 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 031 | Continued From page 7<br>was conducted. It was noted that the State ombudsman's office and telephone number were not included in the emergency communication plan (Ombudsman is a public official who represents the interests of the public, or patients, by investigating, addressing and attempting to resolve complaints for the public, or patients.). At the end of the interview, the admission coordinator stated she would revise the communication plan to include the State Ombudsman's Office and telephone number. | E 031 | | |
| E 033 _SS=C | Methods for Sharing Information<br>CFR(s): 483.73(c)(4)-(6)<br><br>[(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following:<br><br>(4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care.<br><br>(5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.102(c), CORFs under §485.68(c), and RHCs/FQHCs under §491.12(c).]<br><br>(6) [(4) or (5)]A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4). | E 033 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056133 | A. BUILDING _____ B. WING _____ | 07/31/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WEST HILLS HEALTH & REHAB CENTER | 7940 TOPANGA CANYON BLVD. CANOGA PARK, CA 91304 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 033 | Continued From page 8<br>*[For RNHCIs at §403.748(c):] (4) A method for sharing information and care documentation for patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal representative.<br><br>*[For RHCs/FQHCs at §491.12(c):] (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4).<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review,.the facility failed to develop an emergency preparedness plan that included sharing information and medical records for the residents with other providers to maintain the continued care and services, if the residents have to be transferred and/or sheltered in place. This deficient practice could create the risk of not providing the necessary care and services to the patients during the emergency events.<br><br>Findings:<br><br>On July 31, 2019, at 12:15 p.m., during a review of the facility's policies with the admission coordinator, there was no emergency plan developed for sharing information such as medical documentation for residents under the facility's care with other health care providers to maintain continuity of care with an evacuated resident to the next care provider and would also be readily available for resident being sheltered in place. | E 033 | E033 – SS=C<br><br>A. The facility emergency preparedness plan was reviewed and revised to include sharing information such as medical documentation for residents under the facility's care with other health care providers to maintain continuity of care with an evacuated resident and would also be available for resident being sheltered in place.<br><br>B. All residents have the potential to be affected by this deficient practice.<br><br>C. In the event of an emergency which entails evacuating residents, the entire physical chart and medications will be put in a plastic bag and sent with the resident to a safe location.<br><br>D. All trends will be shared with the QAPI Committee for further recommendation and follow up. | 8/20/2019 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056133 | A. BUILDING _____ B. WING _____ | 07/31/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WEST HILLS HEALTH & REHAB CENTER | 7940 TOPANGA CANYON BLVD. CANOGA PARK, CA 91304 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 033 | Continued From page 9<br>During an interview at the time of the record review, the admission coordinator confirmed the finding. | E 033 | | |
| E 037 SS=C | EP Training Program<br>CFR(s): 483.73(d)(1)<br><br>(1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following:<br><br>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.<br>(ii) Provide emergency preparedness training at least annually.<br>(iii) Maintain documentation of the training.<br>(iv) Demonstrate staff knowledge of emergency procedures.<br>*[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following:<br>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles.<br>(ii) Provide emergency preparedness training at least annually.<br>(iii) Maintain documentation of the training.<br>(iv) Demonstrate staff knowledge of emergency procedures.<br><br>*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:<br>(i) Initial training in emergency preparedness policies and procedures to all new and existing | E 037 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056133 | A. BUILDING _____ B. WING _____ | 07/31/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WEST HILLS HEALTH & REHAB CENTER | 7940 TOPANGA CANYON BLVD. CANOGA PARK, CA 91304 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 037 | Continued From page 10<br>hospice employees, and individuals providing services under arrangement, consistent with their expected roles.<br>(ii) Demonstrate staff knowledge of emergency procedures.<br>(iii) Provide emergency preparedness training at least annually.<br>(iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.<br><br>*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:<br>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.<br>(ii) After initial training, provide emergency preparedness training at least annually.<br>(iii) Demonstrate staff knowledge of emergency procedures.<br>(iv) Maintain documentation of all emergency preparedness training.<br><br>*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:<br>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.<br>(ii) Provide emergency preparedness training at least annually.<br>(iii) Demonstrate staff knowledge of emergency | E 037 | E037 – SS=C<br><br>A. All staff were in-serviced on 08/16/2019 regarding the facility emergency preparedness.<br><br>B. All staff have the potential to be affected by this deficient practice.<br><br>C. All new employees will be trained on the facility emergency preparedness during their orientation with the Director of Staff Development and all staff will receive in-service annually.<br><br>D. All trends will be shared with the QAPI Committee for further recommendation and follow up. | 8/20/2019 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056133 | A. BUILDING _____ B. WING _____ | 07/31/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WEST HILLS HEALTH & REHAB CENTER | 7940 TOPANGA CANYON BLVD. CANOGA PARK, CA 91304 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 037 | Continued From page 11<br>procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.<br>(iv) Maintain documentation of all training.<br><br>*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:<br>(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.<br>(ii) Provide emergency preparedness training at least annually.<br>(iii) Maintain documentation of the training.<br>(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.<br><br>*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:<br>(i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.<br>(ii) Provide emergency preparedness training at least annually. | E 037 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056133 | A. BUILDING _____ B. WING _____ | 07/31/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WEST HILLS HEALTH & REHAB CENTER | 7940 TOPANGA CANYON BLVD. CANOGA PARK, CA 91304 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 037 | Continued From page 12<br>(iii) Maintain documentation of the training.<br>(iv) Demonstrate staff knowledge of emergency procedures.<br><br>*[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, the facility failed to ensure the emergency preparedness training provided to the staff included staff knowledge of emergency procedures. The deficient practice could result in staff not knowledgeable of emergency procedures in the event of an emergency disaster.<br><br>Findings:<br><br>On July 31, 2019, at 1:35 p.m., during an interview and review of the documentation the facility had no documentation's indicating that the staff were provided with any in-service training for emergency preparedness. There was no evidence to include that staff demonstrated knowledge of the training when the training was completed. The admission coordinator confirmed and agreed they needed to put a system in place to make sure all the staff including the new staff members are trained at least annually for | E 037 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056133 | A. BUILDING _____ B. WING _____ | 07/31/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WEST HILLS HEALTH & REHAB CENTER | 7940 TOPANGA CANYON BLVD. CANOGA PARK, CA 91304 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 037 | Continued From page 13<br>emergency preparedness plan. | E 037 | | |