| / DEPART | NA WE ACCUPE TMENT OF HEALTH RS FOR MEDICARE | AND HUMAN SERVICES 4/1 | 14,—, | a grant and a second | FORM | 10/10/2014 APPROVED 0938-0391 |
|--------------------------|---|---|-----------------------------|--|--|---|
| STATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPL A. BUILDING | E CONSTRUCTION | (X3) DATE | E SURVEY PLETED |
| | | 056133 | B. WING | : | 1 | C 16/2014 |
| | PROVIDER OR SUPPLIER | AB CENTER | 7 | TREET ADDRESS, CITY, STATE, ZIP CODE 940 TOPANGA CANYON BLVD. CANOGA PARK, CA 91304 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE | (X5) COMPLETION DATE |
| | Department of Publ Abbreviated Survey Complaint Number Representing the D Surveyor ID No. 277 Highest S/S = E 483.10(f)(2) RIGHT RESOLVE GRIEVA A resident has the r facility to resolve gri have, including thos of other residents. This REQUIREMEN by: Based on observat review, the facility fa policy for one out of This had a potentia resolving grievance Findings: According to the ad was originally admit was readmitted on that included hyper right hemiplegia (pa | cts the findings of the ic Health during an and Complaint Visit. CA00409202 - Substantiated. epartment of Public Health: 787, HFEN TO PROMPT EFFORTS TO NCES ight to prompt efforts by the levances the resident may are with respect to the behavior. AT is not met as evidenced alled to follow their grievance of one sample resident(s) (1). If for untimely and delay of s in the future. mission record, Resident 1 the don January 28, 2013 and July 17, 2013, with diagnoses tension (high blood pressure), aralysis on the same side of | F 166 | West Hills Health & & Rehabilitation of makes its best efforts to operate in full compliance with both the Federal and a regulations. Nothing included in this procrection is an admission otherwise. It hills Health & Rehabilitation Center has ubmitted this plan of correction in ordicomply with its regulatory obligation and twaive any objections to the merits of allegation contained herein. The submission of this plan of correction constitutes our allegation of compliance of the facility will follow the facility's grievance policy & procedure in a pland timely basis. Resident 1's air conditioning (a/c) unit has been repland continuously works without any issue. No other a/c unit or resident affected. The maintenance and soc service staff has been inserviced to timely resolve grievances and to also complete grievance & maintenance at all times. Administrator will monitor through the Continuous Quality Improvement (CQI) program on a quarterly basis for continuous compliance. | State lan of Vest as ler to nd does or form NCE rompt aired was ial | 10/17/14 LOS ANGELES COUNTY LEALTH FACILITIES |
| | the body), and right | The fracture. | | | | |
| _ABORATOR | Y DIRECTOR'S OR PROVID | DER/SUPPLIER REPRÉSENTATIVE'S SIGN | NATURE | TITLE Jerry Catama Administrator | 41 | (X6) DATE 0/18/14 |
| Any deficion | cy statement ending with | an astorisk (*) denotes a deficiency wh | ich the institut | tion may be excused from correcting providing | | |

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 tlan 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.

| | OF DEFICIENCIES OF CORRECTION | IDENTIFICATION NUMBER: | | | COMPLETED | | |
|--------------------------|--|--|--------------------|-----|---|----|----------------------------|
| | | 056133 | B. WING | _ | | 1 | 16/2014 |
| | PROVIDER OR SUPPLIER | AB CENTER | | 7 | TREET ADDRESS, CITY, STATE, ZIP CODE 940 TOPANGA CANYON BLVD. CANOGA PARK, CA 91304 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 166 | The Minimum Data July 29, 2014, indic patterns were mode extensive assistant living. On August 13, 2014 observation and int was lying in bed, almember at the bed she felt uncomfortar room temperature of degrees Fahrenheir conditioning system. On August 13, 2014 interview with Famile told the facility shot temperature but the condition of the modern and into Member 1 (MSM 1) unit was not working about it five to ten ratemperature log to able to provide it. A review of the Mai August 2014, did not check or fix the air of the condition of the main facility interview with Licer 1), she stated she for the modern of the condition of the main facility interview with Licer 1), she stated she for the modern of the condition of the main facility in th | Set (MDS) assessment dated ated the resident's cognitive erately impaired and needed be for most activities of daily 4, at 3:30 p.m., during an erview with Resident 1, she ert and oriented, with family side. Resident 1 stated that ble, hot, and irritated. The gauge was between 80 to 81 t. Resident 1 stated that the air in was not working. 4, at 3:54 p.m., during an ly Member 1 (FM 1), he stated taff a week ago regarding the t no action was taken. 4, at 4:05 p.m., during an erview with Maintenance Staff 1, he stated the airconditioning 1. According to him, he knew minutes ago. When asked for 1. When the stated the airconditioning 2. According to him, he knew 1. When asked for 1. When a | F 1 | 166 | | | |
| | | Director of Nursing (DON), she | | | | | |

| | | AND HUMAN SERVICES & MEDIC. SERVICES | | | | FORM | 10/10/2014 ¹ APPROVED 0938-0391 |
|--------------------------|---|--|-------------------|-----|---|------|--|
| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | | SURVEY |
| | | 056133 | B. WING | | | I . | 16/2014 |
| NAME OF F | PROVIDER OR SUPPLIER | | | | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| WEST HI | LLS HEALTH & REHA | AB CENTER | | | 940 TOPANGA CANYON BLVD. ANOGA PARK, CA 91304 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| F 166 | Continued From pa | ge 2 | F | 166 | | | |
| | interview with the S the temperature wa meeting and she sta previous Administra Director to check th There was a work r and followed up by request is to repair also stated that there was completed and Administrator. Whe grievance form and facility in the preser | 2014, at 3:53 p.m., during an ocial Worker (SW), she stated is discussed in the stand-up ated she was there. The stor told the Maintenance is thermostat in the room. equest form that was initiated the corporate office. The work the airconditioning unit. She re was a grievance form that was given to the previous in asked for the copy of the the actions taken by the line of the DON and the or, she was not able to provide | | | | | |
| | interview with the content was not aware or regarding the aircon. The facility's policy Resolution Program the facility will ident. | 2014, at 4 p.m., during an urrent Administrator, he stated if any grievance paperwork aditioning unit. and procedure titled "Concern dated July 2013, indicated ify, investigate, and resolve ats/family members, and | | | | | |
| F 246 SS=D | others. The Administrator coordinator. After re Administrator compincludes recommer recurrences. The Adate reflect conclus forms collected will 483.15(e)(1) REAS | strator is the concern esolution of the concern, the eletes the final review that dations to prevent future dministrator's signature and sion of the concern. Concern be placed in a concern book. ONABLE ACCOMMODATION | F: | 246 | 483.15(e)(1) REASONABLE ACCOMODATION OF | | 10/17/14 |

A resident has the right to reside and receive

NEEDS/PREFERENCES

PRINTED: 10/10/2014 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICARE & SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING C 056133 B. WING 09/16/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7940 TOPANGA CANYON BLVD. **WEST HILLS HEALTH & REHAB CENTER** CANOGA PARK, CA 91304 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION DATE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 246 Continued From page 3 F 246 The facility will ensure residents receive services in the facility with reasonable facility services with reasonable accommodations of individual needs and accommodation of his or her individual preferences, except when the health or safety of needs in regards to comfortable the individual or other residents would be temperature. Resident 1's air endangered. conditioning (a/c) unit has been repaired and continuously works without any issue. No other a/c unit or resident was affected. The maintenance staff has been This REQUIREMENT is not met as evidenced inserviced to ensure residents' rooms temperature is comfortable. Also, the bv: Based on observation, interview, and record maintenance staff will randomly monitor review, the facility failed to ensure that the needs and log room temperature on a weekly for a safe and comfortable temperature was basis. Administrator will monitor through accommodated for one out of one sample the Continuous Quality Improvement resident(s) (1). This had a potential for the (CQI) program on a quarterly basis for increase in the resident's blood pressure and continuous compliance. potential for increased anxiety related to the resident's intolerance for heat. Findings: According to the admission record, Resident 1 was originally admitted on January 28, 2013 and was readmitted on July 17, 2013, with diagnoses that included hypertension (high blood pressure) and depression. The Minimum Data Set (MDS) assessment dated July 29, 2014, indicated the resident's cognitive patterns were moderately impaired and needed extensive assistance from staff members for

most of the activities of daily living.

On August 13, 2014, at 3:30 p.m., during an observation and interview with Resident 1, she was lying in bed, alert and oriented, with family member at the bedside. Resident 1 stated that she felt uncomfortable, hot, and irritated. The room temperature gauge was between 80 to 81

DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

| | OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | l ' ' | X2) MULTIPLE CONSTRUCTION A. BUILDING | | CON | TE SURVEY MPLETED C |
|--------------------------|---|---|--------------------|---------------------------------------|---|------|----------------------------|
| | | 056133 | B. WING | | | | /16/2014 |
| | PROVIDER OR SUPPLIER | AB CENTER | | 7 | TREET ADDRESS, CITY, STATE, ZIP CODE 1940 TOPANGA CANYON BLVD. CANOGA PARK, CA 91304 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDERICLENCY) |) BE | (X5) COMPLETION DATE |
| F 246 | degrees Fahrenhei conditioning system On August 13, 2014 interview with Familihe told the facility's hot temperature bu On August 13, 2014 observation and int Member 1 (MSM 1) was not working. At about it five to ten ratemperature log trable to provide it. On August 13, 2014 interview with Licer 1), she stated she for the Mai August 2014, did not check or repair air of A review of the Wolley 14, 2014, indicated and air conditioning working. The rooms 45. The facility's undate "Accommodation of will receive services accommodation of the Mai August 2014, indicated and air conditioning working. The rooms 45. | t. Resident 1 stated that the air in was not working. 4, at 3:54 p.m., during an ly Member 1 (FM 1), he stated taff a week ago regarding the ton action was taken. 4, at 4:05 p.m., during an erview with Maintenance Staff in he stated the air conditioner ecording to him, he knew minutes ago. When asked for to be reviewed, he was not seed Vocational Nurse 1 (LVN felt hot in the room. 2014, at 3:30 p.m., during an infector of Nursing (DON), she hot at that time. | F 2 | 246 | | | |

DEPARTMENT OF HEALTH AND HUM. SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/10/2014 FORM APPROVED OMB NO. 0938-0391

| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | 056133 | B. WING | ; | | | C 16/2014 |
| NAME OF | PROVIDER OR SUPPLIER | | I | | TREET ADDRESS, CITY, STATE, ZIP CODE | 1 03/ | 10/2014 |
| | | | | ſ | 940 TOPANGA CANYON BLVD. | | į |
| WEST H | ILLS HEALTH & REH | AB CENTER | | c | ANOGA PARK, CA 91304 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 246 | Continued From pa | _ | F2 | 246 | | | · |
| | the resident's envir | | | | | | |
| F 257 SS=E | | FORTABLE & SAFE EVELS | F2 | 257 | 483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS | , | 10/17/14 |
| | temperature levels. | ovide comfortable and safe Facilities initially certified 90 must maintain a of 71 - 81° F | | | The facility will provide comfortable safe temperature levels for the resident 1's air conditioning (a/c) u has been repaired and continuously works without any issue. No other a unit or resident was affected. The | dents. nit / | |
| | by: Based on observa review, the facility f comfortable tempe complained of hot was verified of hot the facility for one of (1). This had a pote resident's blood pre with hypertension a | NT is not met as evidenced tion, interview, and record railed to maintain a safe and rature level for a resident who temperature in her room and temperatures in other rooms in out of one sample residents ential for the increase the essure who was diagnosed and potential to feel more residents who were wearing underpants. | | | maintenance staff has been inservice ensure residents' rooms temperature maintained at a comfortable and satemperature level. Also, the maintenance staff will randomly mound log room temperature on a week basis to ascertain proper temperature. Administrator will monitor through the Continuous Quality Improvement (Continuous Compliance). | re is fe onitor ekly ure. he | |
| | Findings: | | | | | | |
| | was originally adm was readmitted on that included hype | dmission record, Resident 1 itted on January 28, 2013 and July 17, 2013, with diagnoses rtension (high blood pressure), aralysis on the same side of at hip fracture. | | | | | |
| | July 29, 2014, indi- patterns were mod | a Set (MDS) assessment dated cated the resident's cognitive derately impaired and needed ace for most activities of daily | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: CA920000082

DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

| | OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | LE CONSTRUCTION | (X3) DATE SURVE | |
|--------------------------|--|---|--------------------|-----|---|-----------------|----------------------------|
| | | 056133 | B. WING | | | k | 16/2014 |
| | PROVIDER OR SUPPLIER | AB CENTER | | 7 | TREET ADDRESS, CITY, STATE, ZIP CODE 1940 TOPANGA CANYON BLVD. CANOGA PARK, CA 91304 | • | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 257 | On August 13, 2014 observation and int was lying in bed, al member at the bed she felt uncomfortar room temperature degrees Fahrenhei conditioning system. On August 13, 2014 interview with Familia he told the facility shot temperature but On August 13, 2014 observation and int Member 1 (MSM 1) was not working. A about it five to ten ratemperature log to able to provide it. Vichecked rooms 39, temperatures were room 39-82 degree room 41-80 to 81 croom 45-80 to 81 croom 45-80 to 81 croom 45-80 to 81 croom 41, 2014, indicated and air conditioning working. The room 45. | 4, at 3:30 p.m., during an erview with Resident 1, she ert and oriented, with family side. Resident 1 stated that ible, hot, and irritated. The gauge was between 80 to 81 t. Resident 1 stated that the air was not working. 4, at 3:54 p.m., during an ly Member 1 (FM 1), he stated taff a week ago regarding the t no action was taken. 4, at 4:05 p.m., during an erview with Maintenance Staff he stated the air conditioner coording to him, he knew minutes ago. When asked for o be reviewed, he was not when the Surveyor and MSM 1 41, and 45, the following noted: es Fahrenheit degrees Fahrenheit with two | | 257 | | | |
| | interview with Licer | nsed Vocational Nurse 1 (LVN felt hot in the room. | | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDIC. SERVICES

| | D PLAN OF CORRECTION IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING | | COM | COMPLETED | | |
|--------------------------|--|--|---------------------|---|-----------------------------------|----------------------------|
| | | 056133 | B. WING | | | C 16/2014 |
| | PROVIDER OR SUPPLIER | AB CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 7940 TOPANGA CANYON BLVD. CANOGA PARK, CA 91304 | 1 007 | 10/2014 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | | JLD BE | (X5) COMPLETION DATE |
| F 257 | Continued From pa | ge 7 ntenance Request Log dated | F 2 | 57 | | |
| | August 2014, did no check or repair the | ot indicate a requisition to air conditioner. | | | | |
| : | | 2014, at 3:30 p.m., during an irector of Nursing (DON), she not at that time. | | | | |
| | "Maintenance Log", maintenance log in maintenance shop of unless it is requested other authorized pe | ed policy and procedure titled indicated to keep the a designated place in the or work area at all times ed by the Administrator or rson. Keep the maintenance and initial all required repair | | | | |
| | jobs, service jobs, s weekly, monthly, an | service units, and daily, and annual checks and an as possible after they are | | | | |
| F 425 SS=D | 483.60(a),(b) PHAF ACCURATE PROC | RMACEUTICAL SVC - EDURES, RPH | F 4 | 25 483.60(a),(b) PHARMACEUTIC - ACCURATE PROCEDURE, R | | 10/17/14 |
| • | drugs and biologica them under an agre §483.75(h) of this p unlicensed personn | ovide routine and emergency als to its residents, or obtain ement described in eart. The facility may permit all to administer drugs if State by under the general ensed nurse. | | The facility will ensure safe administration of medications by license nurse to residents for the timing and dosage of medication Resident 1 medication is now be provided only by a license nurse other residents are affected with procedure. License nurses have | e proper i. ing No this been | |
| | (including procedur acquiring, receiving | drugs and biologicals) to meet | | inserviced to administer medicat timely and accurate basis. DON randomly observe medication palicensed nurses to ascertain con DON will also monitor through the Continuous Quality Improvement | will ass by apliance. ae | - |
| | The facility must en | nploy or obtain the services of | | program on a quarterly basis for continuous compliance. | | |

DEPARTMENT OF HEALTH AND HUN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | TIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED C | | |
|--------------------------|--|--|--------------------|--|------------------------------|----------------------------|--|
| | | 056133 | B. WING | · | | 09/16/2014 | |
| | PROVIDER OR SUPPLIER | AB CENTER | | STREET ADDRESS, CITY, STATE, ZIP C 7940 TOPANGA CANYON BLVD. CANOGA PARK, CA 91304 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | I SHOULD BE | (X5) COMPLETION DATE | |
| F 425 | a licensed pharmad | cist who provides consultation e provision of pharmacy | F4 | 25 | | | |
| | by: Based on observareview, the facility fadministration of migiving the medication member to administration of the literature of the literature of the medications that might documentation of the actually administer administration may breaking or crushin | tion, interview, and record ailed to ensure safe edications to a resident by ons to the resident's family ster the medication without the icensed nurse for one out of ht(s) (1). This had a potential y in administration of the ay result to inaccurate the time the medication was ed and the method of be inconsistent such as g of the medications and auce by the family member. | | | | | |
| | observation, Reside son at the bedside. According to the Minimum Data | Imission record, Resident 1 tted on January 28, 2013 and July 17, 2013, with diagnoses tension, depression, seizure racture, and respiratory failure. Set (MDS) assessment dated | | | | | |
| | July 29, 2014, indic | ated the resident's cognitive erately impaired and needed | | , | | | |

DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|--|--|---|--|---|--|-------------------------------|--------------------|
| | | 056133 | B. WING | | | C 09/16/2014 | |
| NAME OF I | PROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | <u> </u> | 10/2014 |
| WEST H | LLS HEALTH & REHA | AB CENTER | | | 7940 TOPANGA CANYON BLVD. CANOGA PARK, CA 91304 | | |
| (X4) ID | SUMMARY STA | TEMENT OF DEFICIENCIES | ID | | PROVIDER'S PLAN OF CORRECTION | <u> </u> | (X5) |
| PREFIX TAG | (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | PREF | PREFIX TAG (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES DEFICIENCY) | | BE | COMPLETION DATE |
| F 425 | Continued From pa | ge 9 | F4 | 125 | | | |
| | extensive assistance from staff members for most of the activities of daily living. | | | | | | |
| | | sician's orders (Order or the month of September 1, following: | | | | | |
| | tablet by mouth one | tablet 81 milligrams (mg) one time a day for cident (CVA) prophylaxis April | | | | · | |
| | five mg. Give two ta | coated (EC) delayed release ablets by mouth one time a day ald for loose stool dated | | | | | |
| | | 450 mg. Give two tablets by ay for prophylaxis dated | | | | | |
| | mouth one time a d | 500 mg. Give two capsules by ay related to other and bidemia dated February 16, | | | | | |
| | one tablet by mouth unspecified essenti | ochloride (HCl) 25 mg. Give n two times a day related to al hypertension. Hold for sure below 110 dated July 17, | | | | | |
| | mouth one time a d | ide tablet - Give one tablet by ay related to unspecified ion dated July 17, 2013. | | | | | · |
| | | 0 mg. Give one tablet by day related to other July 17, 2013. | | | | | |

DEPARTMENT OF HEALTH AND HUN SERVICES CENTERS FOR MEDICARE & MEDICAL SERVICES

| | F CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | | COMPLETED | | |
|--------------------------|--|---|---------------------|-----|---|----|----------------------------|
| | | 056133 | B. WING | | | | C 16/2014 |
| | PROVIDER OR SUPPLIER | AB CENTER | 1 , | 79 | REET ADDRESS, CITY, STATE, ZIP CODE 140 TOPANGA CANYON BLVD. ANOGA PARK, CA 91304 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 425 | 8. Lexapro 10 mg tarmouth one time a disorder manifested dated December 30 9. Lopid 600 mg takevery 12 hours related August 4, 2014. 10. Lopressor table times a day related Hold for systolic bloudly 17, 2013. 11. Milk of Magnesi centimeters (cc). Gievery day for constitus ofteners are ineffered 12. Norco tablet 5-3 mouth every six housevere pain dated August 4. Norvasc tablet from the one time and hypertension. Hold below 110 dated June 12. Norco tablet 13. Norvasc tablet 14. Norvasc tablet 15-3 mouth one time and hypertension. Hold below 110 dated June 15-3 mouth every six housevere pain dated August 15-3 mouth one time and hypertension. Hold below 110 dated June 15-3 mouth every six housevere pain dated August 15-3 mouth one time and hypertension. Hold below 110 dated June 15-3 mouth every six housevere pain dated August 15-3 mouth every six housevere pa | ablet. Give one tablet by any related to depressive d by feeling of hopelessness 0, 2013. Delet. Give one tablet by mouth ted to hyperlipidemia dated It. Give 25 mg by mouth two to essential hypertension. Hod pressure below 110 dated as suspension 30 cubic live 30 cc by mouth as needed pation if ordered stool ctive dated July 17, 2013. B25 mg. Give one tablet by lives as needed for moderate to hugust 1, 2013. Five mg. Give one tablet by ay related to essential for systolic blood pressure | F 4 | 125 | DEFICIENCY) | | |
| | 2013. 15. Potassium Chlo tablet eight milliequ by mouth one time | reflux disease) dated July 17, oride extended release (ER) ivalent (meq). Give two tablets a day for potassium November 21, 2013. | | | | | |
| | | | 1 | - 1 | | 4 | |

DEPARTMENT OF HEALTH AND HUN SERVICES CENTERS FOR MEDICARE & MEDICAL SERVICES

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | MPLETED |
|--------------------------|---|--|---------------------|---|---------|----------------------------|
| | | 056133 | B. WING | · | 09 | C 9/16/2014 |
| | PROVIDER OR SUPPLIER | AB CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 7940 TOPANGA CANYON BLVD. CANOGA PARK, CA 91304 | | 1012017 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| F 425 | 16. Tylenol 325 mg every four hours as February 17, 2013. A review of the Self Assessment dated interdisciplinary tea was not safe for the drugs. Licensed nu for proper timing and A review of the care family member will the resident. On August 13, 2014 interview with Famil Licensed Vocational gives him his mother should not have do to the next resident of the medications to the next resident routine medications according to LVN2. The facility's policy "Medication Adminidated April 2008, in administered as pregood nursing principersons legally autited in the self-self-self-self-self-self-self-self- | Give two tablets by mouth needed for mild pain dated Administration of Drugs July 18, 2013, indicated the m (IDT) had determined that it e resident to self-administer rese to administer medications ad dosage. It plan did not indicate that a administer the medications of the self-administer and the self-administer that a administer the medications of the self-administer the self-administer the medications of the self-administer the self-administer the self-administer the self-administer the medications of the self-administer the self-administer the self-administer that a part of the self-administer that a self-administer the self-administer that a self-ad | F 4 | 25 | | |

DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICAL SERVICES

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|---|---|--|---|-------------------------------|----------------------------|
| | | 056133 | B. WING | | | | 6/2014 |
| | ROVIDER OR SUPPLIER | AB CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 7940 TOPANGA CANYON BLVD. CANOGA PARK, CA 91304 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 425 | allow administering unnecessary interruadministered only be pharmacy or other plaws and regulation. The person who preadministration is the dose. The resident administration to encompletely ingested administers the meadministration on the street of the s | sility has sufficient staff to of medications without uptions. Medications are by licensed nursing, medical, personnel authorized by state is to administer medications. The person who administers the disalways observed after assure that the dose was did. The individual who dication dose records the persident's MAR (medication and) directly after the | F4 | 125 | | | |
| | | | | | | | |

| | | AND HUMAN SERVICES | | | FORM | 10/10/2014 APPROVED | | |
|---|--|---|--|---|---|-------------------------------|--|--|
| | | & MEDIC/ SERVICES | , | | | <u>. 0938-0391</u> | | |
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | CON | (X3) DATE SURVEY COMPLETED | | |
| 056133 | | B. WING | | C 09/16/2014 | | | | |
| NAME OF F | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP C | ODE | | | |
| WEST LI | LLS HEALTH & REHA | AD CENTED | l | 7940 TOPANGA CANYON BLVD. | | | | |
| WEST III | LLO HEALIN & KENA | AB CENTER . | J | 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) | | COMPLETION DATE | | |
| F 246 | Continued From page 5 | | F 2 | F 246 | | | | |
| | the resident's enviro | onment. | | | | 1 | | |
| F 257 | 483.15(h)(6) COMF | FORTABLE & SAFE | F2 | 57 483.15(h)(6) COMFORTABI | _E & | 10/17/14 | | |
| SS=E | TEMPÈRÀTURE LEVELS | | | SAFE TEMPERATURE LEV | | | | |
| | The facility must pro | ovide comfortable and safe | | The facility will provide com | ortable and | | | |
| | | Facilities initially certified | | safe temperature levels for t | | | | |
| | after October 1, 199 | | | The room temperature gaug | e was 80- | | | |
| | temperature range | of 71 - 81° F | | 81degrees at time of visit wh | | | | |
| | | | | proper levels. Resident 1's a | | | | |
| | This DECLUDEMEN | NT is not met as evidenced | | conditioning (a/c) unit has be | | | | |
| | by: | 11 is not met as evidenced | | and continuously works without any issue. No other a/c unit or resident was | | | | |
| | | ion, interview, and record | | affected. The maintenance s | | | | |
| | | ailed to maintain a safe and | | inserviced to ensure residen | | | | |
| • | comfortable temperature level for a resident who | | | temperature is maintained a | | | | |
| | | emperature in her room and | | comfortable and safe tempe | | | | |
| | was verified of hot temperatures in other rooms in the facility for one out of one sample residents | | | Also, the maintenance staff | | | | |
| ٠ | | | | monitor and log room tempe | | | | |
| | | ential for the increase the | | weekly basis to ascertain pro | | | | |
| • | | ssure who was diagnosed | | temperature. Administrator v | | | | |
| | | nd potential to feel more | | through the Continuous Qua | | | | |
| | uncomfortable for residents who were wearing plastic disposable underpants. | | | Improvement (CQI) program | | | | |
| | piastic disposable d | · | | quarterly basis for continuou compliance. | S | | | |
| | Findings: | | | compliance. | • | | | |
| | | mission record, Resident 1 | | | • | | | |
| | was originally admitted on January 28, 2013 and | | | | | | | |
| | | July 17, 2013, with diagnoses | | | | | | |
| | | tension (high blood pressure), | | · | | | | |
| | right hemiplegia (pa the body), and right | aralysis on the same side of | | | | | | |
| | uie body), and right | . inp naciule. | | | | | | |
| | | Set (MDS) assessment dated | | | | | | |
| | | ated the resident's cognitive | : | | | | | |
| | | erately impaired and needed | | . | | | | |
| | extensive assistant | ce for most activities of daily | | | • | | | |

living.

PRINTED: 10/10/2014

| CENTER | RS FOR MEDICARE | & MEDICA SERVICES | | | | | 0938-0391 | | |
|---|--|---|--|--|--|---|-----------|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056133 | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | • | (X3) DATE SURVEY COMPLETED | | | |
| | | B. WING | | | C 09/16/2014 | | | | |
| NAME OF PROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | | | | |
| WEST HILLS HEALTH & REHAB CENTER | | | | 7940 TORANGA 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 SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY) | TIVE ACTION SHOULD BE CED TO THE APPROPRIATE | | | |
| F 246 | Continued From pa | • | F 2 | 246 | | | | | |
| F 257 SS=E | 483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS | | F 257 | | 483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS | | 10/17/14 | | |
| | | | | | The facility will provide comfortable safe temperature levels for the rest The room temperature gauge was \$1degrees at time of visit which is proper levels. Resident 1's air sconditioning (a/c) unit has been re | idents. - 9 0- (j.) with in | | | |
| | by: Based on observate review, the facility for comfortable temper complained of hot to the facility for one of the facility for one of the same of the facility for one of the same of th | NT is not met as evidenced tion, interview, and record alled to maintain a safe and rature level for a resident who emperature in her room and temperatures in other rooms in out of one sample residents ential for the increase the | | | and continuously works without an issue. No other a/c unit or resident affected. The maintenance staff had inserviced to ensure residents' roctemperature is maintained at a comfortable and safe temperature iAlso, the maintenance staff will rail monitor and log room temperature weekly basis to ascertain proper | y was as been oms level. | | | |
| · . | resident's blood pre with hypertension a | essure who was diagnosed and potential to feel more esidents who were wearing | | | Itemperature. Administrator will mo through the Continuous Quality Improvement (CQI) program on a quarterly basis for continuous compliance. | nitor | | | |
| | Findings: | ţ | | | • | | | | |
| | was originally admit was readmitted on that included hyper | Imission record, Resident 1 tted on January 28, 2013 and July 17, 2013, with diagnoses tension (high blood pressure), aralysis on the same side of this fracture. | | | | | | | |
| | July 29, 2014, indic | Set (MDS) assessment dated atted the resident's cognitive erately impaired and needed ce for most activities of daily | : | • | | | | | |

DEPARTMENT OF HEALTH AND HUM SERVICES

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