STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055146	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Valley Nursing Center	7660 Wyngate St Tujunga, CA 91042

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39550 Based on interview and record review the facility failed to ensure resident's personal belongings were returned to the resident's representative for one of three sampled residents (Resident 1). This deficient practice resulted in the violation of Resident 1's representative's right by not receiving Resident 1's belongings upon Resident 1's discharge. Findings: A review of Resident 1's Admission Record indicated the facility originally admitted Resident 1 on [DATE] and readmitted on [DATE] with diagnoses that included chronic myeloid leukemia (slowly progressing and uncommon type of blood-cell cancer that begins in the bone marrow [a spongy substance found in the center of the bones]), Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), dysphagia (difficulty swallowing), dementia (impaired ability to remember, think, or make decisions that interferes with a resident's daily life and activities), and benign prosthetic hyperplasia (a condition in men in which the prostate gland [part of the male anatomy] is enlarged) with lower urinary symptoms (include sudden urges to urinate, a weak urine stream and urine leaks). A review of Resident 1's Minimum Data Set (MDS- a standardized assessment and care planning tool) dated [DATE], indicated Resident 1 was sometimes able to be understood by others and sometimes able to understand others. The MDS further indicated that Resident 1 had severely impaired cognition (mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making. The MDS indicated Resident 1 was totally dependent on staff with bed mobility (movement), transfers, dressing, eating, toilet use, personal hygiene, and bathing. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and concurrent record review with the Social Services Director (SSD) on [DATE] at 10:00 a.m., the SSD stated that resident's belongings are checked and inventoried upon admission and yearly. Resident's inventory is documented on a form titled Resident's Clothing and Possessions and placed in the resident's chart. The SSD continued to state that when a resident is transferred out or expired the social services department collects the resident's belongings and are kept for 30 days. The social services department will then document attempts to contact the resident's responsible party or representative to pick up the resident's belongings. The SSD reviewed Resident 1's medical record including Resident 1's progress notes and stated that there was no documented evidence found indicating Resident 1's belongings were picked up nor were there any documented evidence of attempts to contact Resident 1's responsible party. A review of Resident 1's Resident's Clothing and Possessions form on Discharge section dated [DATE] indicated Resident 1's responsible party refused to sign. During an interview with Family Member 1 (FM 1) on [DATE] at 3:05 p.m., FM 1 stated that she did not receive Resident 1's belongings. During an interview and concurrent record review with Licensed Vocational Nurse 2 (LVN 2) on [DATE], LVN 2 reviewed Resident 1's document titled Resident's Clothing and Possessions on discharge date d [DATE] and stated that he signed as a witness to the document. LVN 2 stated that he was working on [DATE] during the 3:00 p.m. to 11:00 p.m. shift. LVN 2 stated Resident 1's family member came to the facility on [DATE] however, refused to sign the Resident's Clothing and Possessions document and did not take Resident 1's belongings. During a follow up interview and concurrent record review with the SSD on [DATE] at 3:41 p.m., the SSD reviewed Resident 1's medical record including Resident 1's progress notes, and stated there was no documented evidence that FM 1 picked up Resident 1's belongings. The SSD continued to state that if Resident 1's belongings were picked up by FM 1 and FM 1 refused to sign the form, the licensed nurse should still have documented in the progress notes confirming that FM 1 had picked up Resident 1's belongings. The SSD further stated the facility should have made attempts to contact Resident 1's responsible party to return Resident 1's personal belongings. The SSD stated the attempts should have also been documented in Resident 1's medical record. During a review of the facility's policy titled Resident Personal Belongings, reviewed [DATE], indicated following the discharge or death of a resident, all personal clothing and items of a customized personal nature are to be given to the designated resident representative. Inventories of all items are to be reviewed and examined by Social Services designee and the resident's representative. Recipients of such personal items at the time of discharge or death shall sign off with their legal signature, acknowledging receipt of all personal belongings presented. Notification of the deceased resident's family or responsible agent will be accomplished by means of a Certified Letter-Return Receipt Requested which shall be sent as soon as possible.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39550 Based on interview and record review, the facility failed to develop a comprehensive person-centered care plan (a written course of action that helps a resident achieve outcomes that improve their quality of life) for one of three sampled residents (Resident 1), who was identified to have an indwelling catheter (a flexible plastic or rubber tube that is inserted into the bladder to drain the urine). This deficient practice had the potential to negatively affect the delivery of care and services to Resident 1. Findings: A review of Resident 1's Admission Record indicated the facility originally admitted Resident 1 on 4/14/2022 and readmitted on [DATE] with diagnoses that included chronic myeloid leukemia (slowly progressing and uncommon type of blood-cell cancer that begins in the bone marrow [a spongy substance found in the center of the bones]), Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), dysphagia (difficulty swallowing), dementia (impaired ability to remember, think, or make decisions that interferes with a resident's daily life and activities), and benign prosthetic hyperplasia (a condition in men in which the prostate gland [part of the male anatomy] is enlarged) with lower urinary symptoms (include sudden urges to urinate, a weak urine stream and urine leaks). A review of Resident 1's Minimum Data Set (MDS- a standardized assessment and care planning tool) dated 2/13/2023, indicated Resident 1 was sometimes able to be understood by others and sometimes able to understand others. The MDS further indicated that Resident 1 had severely impaired cognition (mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making. The MDS indicated Resident 1 was totally dependent on staff with bed mobility (movement), transfers, dressing, eating, toilet use, personal hygiene, and bathing. A review of Resident 1's Skin Only Evaluation form, dated 1/30/2023 timed at 7:58 p.m., indicated Resident 1 had a foley catheter (a common type of indwelling catheter) in place. During an interview and concurrent record review with Registered Nurse 1 (RN 1) on 4/17/2024 at 2:30 p.m., RN 1 reviewed Resident 1's Clinical Admission Evaluation form dated 1/30/2023 timed at 7:47 p.m. and stated that Resident 1 was readmitted with an indwelling catheter in place due to urine retention. RN 1 then reviewed Resident 1's care plans from 1/30/2023 to 3/7/2023 and stated that there was no documented evidence that a care plan was developed to address Resident 1's indwelling catheter. RN 1 further stated that a care plan specific to Resident 1's indwelling catheter is important to guide staff on what specific interventions including care and services to provide Resident 1 relating to indwelling catheter. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure titled Comprehensive Care Plans, reviewed 1/10/2024, indicated it is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, and psychosocial needs. The comprehensive care plan will describe, at a minimum, the following: A. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39550 Based on interview and record review the facility to ensure one of three sampled residents (Resident 1) received care and services in accordance with professional standards of practice by failing to: 1. Administer Resident 1's Acetaminophen (a medication used to relieve mild to moderate pain) as prescribed by the Attending Physician when resident reported a ten out of ten pain on 12/28/2022. 2. Ensure a pain risk assessment was completed when a new onset of pain was identified on 12/28/2022 and quarterly as per facility policy. These deficient practices resulted in Resident 1 experiencing severe untreated pain (pain rated at ten out of ten, on a pain scale from zero to ten, where ten is the worst possible pain) on 12/28/2022 and placed Resident 1 at risk for further pain and suffering. Findings: A review of Resident 1's Admission Record indicated the facility originally admitted Resident 1 on 4/14/2022 and readmitted on [DATE] with diagnoses that included chronic myeloid leukemia (slowly progressing and uncommon type of blood-cell cancer that begins in the bone marrow [a spongy substance found in the center of the bones]), Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), dysphagia (difficulty swallowing), dementia (impaired ability to remember, think, or make decisions that interferes with a resident's daily life and activities), and benign prosthetic hyperplasia (a condition in men in which the prostate gland [part of the male anatomy] is enlarged) with lower urinary symptoms (include sudden urges to urinate, a weak urine stream and urine leaks). A review of Resident 1's Minimum Data Set (MDS- a standardized assessment and care planning tool) dated 2/13/2023, indicated Resident 1 was sometimes able to be understood by others and sometimes able to understand others. The MDS further indicated that Resident 1 had severely impaired cognition (mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making. The MDS indicated Resident 1 was totally dependent on staff with bed mobility (movement), transfers, dressing, eating, toilet use, personal hygiene, and bathing. A review of Resident 1's Change of Condition (when there is a sudden change in a resident's health) Evaluation Form dated 12/28/2022 timed at 11:30 a.m., indicated Resident 1 reported a ten out of ten pain on his right shoulder and right arm. A review of Resident 1's Physician's Order dated 7/23/2022 indicated to administer Acetaminophen tablet 650 milligrams (mg- unit of measure) by mouth every eight (8) hours as needed for severe pain (pain rated at eight or higher out of ten). A review of Resident 1's Physician's Order dated 12/28/2022 timed at 10:12 a.m. indicated to transfer Resident 1 to General Acute Care Hospital 1 (GACH 1) for further evaluation of right arm pain. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. During an interview and concurrent record review with Register Nurse 1 (RN 1) on 4/19/2024 11:28 a.m., RN 1 reviewed Resident 1's Medication Administration Record (MAR- a report detailing the medications administered to a resident) for the month of December 2022. RN 1 stated that Resident 1's MAR does not indicate that Resident 1 was administered Acetaminophen tablet 650 mg by mouth as needed for severe pain as ordered on 12/28/2022 at around 11:30 a.m. when severe pain to the right should and right arm was noted. RN 1 further stated that when a resident complains of pain, the pain should be assessed, and pain medication should have been offered and administered based on the physician's order and documented in the MAR. After pain medication is administered, the licensed nurse should have re-assessed the resident if the medication was effective and evaluate if further interventions are needed. 2. During an interview and concurrent record review with RN 1 on 4/19/2024 at 12:30 p.m., RN 1 stated that pain risk assessments are done upon admission, quarterly (every three months), and as needed if resident complains of any new onset of pain. Upon review of Resident 1's pain risk assessments, there was no documented evidence found a pain risk assessment was completed on 12/28/2022 when Resident 1 complained of a new onset of pain and there was no documented evidence a quarterly pain risk assessment was completed for the month of November 2022. When asked about the importance of a pain risk assessment, RN 1 stated that it is a tool the facility uses to thoroughly assess a resident's pain and helps the facility implement a better plan of care to address and effectively manage Resident 1's pain. A review of the facility provided policy and procedure titled Pain Management, reviewed date 1/10/2024, indicated the facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Under pain management and treatment: Pharmacological interventions will follow a systemic approach for selecting medications and doses to treat pain. A review of the facility provided policy and procedure titled Pain Management, reviewed date 1/10/2024, indicated under recognition: 1. In order to help a resident attain or maintain his/her highest practicable level of physical, mental and psychosocial well-being and to prevent or manage pain, the facility will: a. Recognize when the resident is experiencing pain and identify circumstances when the pain can be anticipated; b. Evaluate the resident for pain and the cause(s) upon admission, during ongoing scheduled assessments, and when a significant change in condition or status occurs.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39550 Based on interview and record review, the facility failed to implement their facility's medication administration policy by failing to ensure a licensed nurse signed the Medication Administration Record (MAR- a report detailing the medications administered to a resident by a healthcare professional) after administering Albuterol Sulfate (a medication used to treat wheezing [a high pitched or coarse whistling sound heard when one breathes] and shortness of breath (SOB) caused by breathing problems) to one of three sampled residents (Resident 1) on 3/7/2023. This deficient practice had the potential to result in medication errors and had the potential to result in confusion on the delivery of care and services. Findings: A review of Resident 1's Admission Record indicated the facility originally admitted Resident 1 on 4/14/2022 and readmitted on [DATE] with diagnoses that included chronic myeloid leukemia (slowly progressing and uncommon type of blood-cell cancer that begins in the bone marrow [a spongy substance found in the center of the bones]), Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), dysphagia (difficulty swallowing), dementia (impaired ability to remember, think, or make decisions that interferes with a resident's daily life and activities), and benign prosthetic hyperplasia (a condition in men in which the prostate gland [part of the male anatomy] is enlarged) with lower urinary symptoms (include sudden urges to urinate, a weak urine stream and urine leaks). A review of Resident 1's Minimum Data Set (MDS- a standardized assessment and care planning tool) dated 2/13/2023, indicated Resident 1 was sometimes able to be understood by others and sometimes able to understand others. The MDS further indicated that Resident 1 had severely impaired cognition (mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making. The MDS indicated Resident 1 was totally dependent on staff with bed mobility (movement), transfers, dressing, eating, toilet use, personal hygiene, and bathing. A review of Resident 1's Physician's Order dated 3/1/2023 at 9:34 p.m., indicated to administer Albuterol Sulfate Inhalation Nebulization (involves using a compressed air through a nebulizer [a medical device that delivers liquid medicine into a fine mist that be inhaled into the lungs] to convert liquid medications into a mist that can then be breathed in by the resident) Solution (2.5 milligrams [mg- unit of measure]/3 milliliters [ml- unit of measure]) 0.083% (Albuterol Sulfate) 3 ml inhale orally (by mouth) via nebulizer every 4 hours as needed for SOB or wheezing. A review of Resident 1's progress notes dated 3/7/2023 at 5:20 p.m., indicated Resident 1 received a breathing treatment (Albuterol Sulfate Inhalation Nebulization) at around 1:00 p.m. on 3/7/2023. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and concurrent record review with Registered Nurse 1 (RN 1) on 4/18/2024 at 4:12 p.m., RN 1 stated that after the licensed nurse administers medications as ordered by the physician, the licensed nurse is to document in the resident's MAR. RN 1 reviewed Resident 1's MAR from 3/1/2023 to 3/7/2023. RN 1 stated that there was no documented evidence found that Resident 1 received his Albuterol Sulfate Inhalation Nebulization Solution on 3/7/2023 at around 1:00 p.m. RN 1 then reviewed Resident 1's progress notes dated 3/7/2023 at 5:20 p.m., RN 1 stated that the licensed nurse should have documented Resident 1 received his Albuterol Sulfate Inhalation Nebulization Solution in the MAR and not in the nursing progress notes. A review of the facility's policy and procedure titled Medication Administration, reviewed 1/10/2024, indicated medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice. The policy further indicated to sign MAR after medication administration.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39550 Based on interview, and record review, the facility failed to ensure that orientation was provide to hospice (a type of medical care for residents who are in the last stages of life) staff as per facility for two of two sampled residents (Resident 1 and Resident 2) as per facility policy. This deficient practice had the potential to delay coordination and delivery of hospice services. Findings: A review of Resident 1's Admission Record indicated the facility originally admitted Resident 1 on 7/20/2022 and readmitted Resident 1 on 1/30/2023 with diagnoses that included chronic myeloid leukemia (slowly progressing and uncommon type of blood-cell cancer that begins in the bone marrow [a spongy substance found in the center of the bones]), Alzheimer's disease (A progressive disease that destroys memory and other important mental functions), dysphagia (difficulty swallowing), dementia (impaired ability to remember, think, or make decisions that interferes with a resident's daily life and activities), and benign prosthetic hyperplasia (a condition in men in which the prostate gland [part of the male anatomy] is enlarged) with lower urinary symptoms (include sudden urges to pee, a weak urine stream and urine leaks). A review of Resident 1's Minimum Data Set (MDS- a standardized assessment and care planning tool) dated 2/13/2023, indicated Resident 1 was sometimes able to be understood by others and sometimes able to understand others. The MDS further indicated that Resident 1 had severely impaired cognition (mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making. The MDS indicated Resident 1 was totally dependent on staff with bed mobility (movement), dressing, eating, toilet use, and personal hygiene. A review of Resident 1's physician's orders dated 3/1/2023 at 9:27 p.m., indicated to admit Resident 1 to hospice under routine level of care for primary diagnosis Alzheimer's disease. A review of Resident 2's Admission Record indicated the facility originally admitted Resident 2 on 1/16/2021 with diagnoses that included Alzheimer's disease, dysphagia, and weakness. A review of Resident 2's MDS dated [DATE], indicated Resident 2 was sometimes able to be understood and sometimes able to understand others. The MDS further indicated that Resident 2 had severely impaired cognitive skills for daily decision making. The MDS indicated Resident 2 was totally dependent on staff with bed mobility, dressing, eating, toilet use, and personal hygiene. A review of Resident 2's physician's orders dated 8/16/2023, indicated to admit Resident 2 to hospice. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and concurrent record review with the Director of Staff Development (DSD) on 4/18/2024 at 12:55 p.m., the DSD stated that when the facility has a new employee, the facility will provide a thorough orientation of the facility and facility policies. When asked hospice staff's orientation. The DSD stated that hospice staff do not go thorough orientation in the facility. DSD stated that Hospice staff is provided with orientation to the lay out of the facility such as the residents' rooms, where to get linen, and the shower rooms. When asked if facility policies are discussed with hospice staff, the DSD stated that no policies are discussed with the hospice staff. The DSD further stated that orientation is only given verbally to hospice staff and there is no documentation of orientation provided to hospice staff. During an interview the Administrator (ADM) on 4/19/2024 at 1:53 p.m., when asked if any orientation is provided to hospice staff, the ADM stated that there is no formal orientation provided to hospice staff. The ADM further stated that he does not feel like hospice staff should be provided any more orientation than what the facility already provides. The ADM continued to state that hospice staff orientation is not documented. A review of the facility's policy and procedure titled Hospice Services Facility Agreement, reviewed date 1/10/2024, indicated the designated member of the facility working as hospice representative is responsible for: e. Ensuring that the facility provides orientation to hospice staff of the following: i. Facility policy and procedure; ii. Resident rights; iii. Appropriate forms; iv. Record keeping requirements.