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	06/20/2024

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. 42275 Based on interview and record review, the facility failed to arrange timely a nephrology (branch of medicine concerned with the kidneys) consult for one of six sampled residents (Resident 1) when on 8/10/2023, the facility admitted Resident 1 with a follow up order for a nephrology appointment in one week, however, the facility did not arrange the follow up appointment until 9/21/2023. This deficient practice had the potential to result in a delay of necessary care and services. Findings: A review of Resident 1's Admission Record indicated the facility admitted Resident 1 on 8/10/2023 with diagnoses that included thoracic (middle portion of the spine) compression fracture (break in a bone caused by pressure and in which the bone collapses), rheumatoid arthritis (a disease that causes severe inflammation of the joints) and acute kidney failure (occurs when the kidneys suddenly become unable to filter waste products from the blood). A review of Resident 1's Minimum Data Set (MDS - a standardized assessment and care-planning tool) dated 11/17/2023, indicated Resident 1 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding through thought, experience and the senses) and needed total assistance from staff for toileting hygiene, maximum assistance from staff for lower body dressing, and moderate assistance for mobility (movement). A review of Resident 1's General Acute Care Hospital 1 (GACH 1) discharge instructions dated 8/10/2023 indicated to arrange for the facility to arrange a follow up with a nephrologist (a medical doctor who specializes in diagnosing and treating kidney conditions) in one week. A review of Resident 1's Physician's Order dated 9/21/2023 indicated that Resident 1 had a nephrology appointment on 9/26/2023 at 10:30 a.m. During an interview and concurrent record review with Registered Nurse 1 (RN 1) on 6/20/2024 at 3:50 p.m., RN 1 reviewed Resident 1's GACH 1 discharge instructions dated 8/10/2023 and stated that the nephrology follow up appointment was arranged on 9/26/2023. RN 1 stated that the facility received the physician's order to arrange Resident 1's nephrology follow up in a week from 8/10/2023, however, the facility did not arrange the follow up appointment until 9/21/2023. RN 1 further stated that the facility did not notify Resident 1's attending physician (the primary physician who is responsible for managing the resident's medical care) of the delayed nephrology appointment. (continued on next page)

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

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Nursing (DON) on 6/20/2023 at 5:00 p.m., the DON stated that the facility should have made arrangements for Resident 1's nephrology follow-up in a week as indicated in the discharge instructions from GACH 1. The DON further stated that the licensed nurses should have notified Resident 1's attending physician for any delayed or missed physician orders. A review of the facility's policy and procedure (P&P) titled, Consulting Physician/Practitioner Orders last reviewed on 1/10/2024, indicated, the attending physician shall authenticate orders for the care and treatment of assigned residents. For consulting physician orders received in writing, the nurse in a timely manner will follow facility procedures for verbal or telephone orders including noting the order. A review of the facility's P&P titled, Physician Services last reviewed on 1/10/2024, indicated, The resident's attending physician is responsible for prescribing new therapy . to ensure that the resident receives quality care and medical treatments.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42275 Based on interview and record review, the facility failed to ensure that the Physician Progress Notes (record that documents the physician's role in the assessment, evaluation, and care of residents) were completed as required, for one of six sampled residents (Resident 1). This deficient practice had the potential for inconsistent care coordination due to incomplete records and placed Resident 1 at risk for poor continuity of care and care needs. Findings: A review of Resident 1's Admission Record indicated the facility admitted Resident 1 on 8/10/2023 with diagnoses that included thoracic (middle portion of the spine) compression fracture (break in a bone caused by pressure and in which the bone collapses), rheumatoid arthritis (a disease that causes severe inflammation of the joints) and acute kidney failure (occurs when the kidneys suddenly become unable to filter waste products from the blood). A review of Resident 1's Minimum Data Set (MDS - a standardized assessment and care-planning tool) dated 11/17/2023, indicated Resident 1 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding through thought, experience and the senses) and needed total assistance from staff for toileting hygiene, maximum assistance from staff for lower body dressing, and moderate assistance for mobility (movement). A review of Resident 1's Physician's Order dated 9/20/2023 indicated that Resident 1 had an appointment with a spine specialist (a doctor who specializes in the treatment and conditions that affect the spine) on 9/27/2023 at 11:00 a.m. A review of Resident 1's Progress Notes dated 9/27/2023 timed at 12:54 p.m., indicated that Resident 1 returned to the facility on [DATE] at 12:30 p.m. from a doctor's appointment (unspecified). During an interview and concurrent record review with the Medical Records Director (MRD) on 6/20/2024 at 3:45 p.m., when the MRD was asked for the spine specialist consultation notes from the 9/27/2023 appointment with the spine specialist, the MRD stated that the consultation notes were not in the electronic medical records system (a digital collection of medical information about a resident that is stored on a computer), neither in Resident 1's clinical records. During an interview with the Director of Nursing (DON) on 6/20/2023 at 4:54 p.m., the DON stated that the facility was unable to locate the consultation notes from the spine specialist for the 9/27/2023 appointment. The DON further stated the facility should ensure and maintain the physician consultation progress notes in the resident's chart, as it is an important tool to communicate the treatment plans and care needed for the residents. The DON stated the facility will contact the spine specialist to obtain a copy of the consultation notes for the 9/27/2023 appointment. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's P&P titled, Physician Services last reviewed on 1/10/2024, indicated, Physician orders and progress notes shall be maintained in accordance with current OBRA (stands for Omnibus Budget Reconciliation Act, also known as the Nursing Home Reform Act of 1987, setting federal standards of how care should be provided to residents) regulations and facility policy.

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. 42275 Based on interview and record review, the facility failed to provide timely radiology (a branch of medicine that uses imaging technology to diagnose and treat disease) service for one of six sampled residents (Resident 1) when on 9/27/2023, Resident 1's physician ordered for a magnetic resonance imaging (MRI - a noninvasive medical imaging test that produces detailed images of the internal structure of the body) for lumbar (lower part of the back) and thoracic (middle portion of the spine) compression fracture (break in a bone caused by pressure and in which the bone collapses) however, the facility did not arrange the MRI until 10/10/2023. This deficient practice had the potential to result in an undiagnosed problem which could have placed Resident 1 at higher risk for a decline in health. Findings: A review of Resident 1's Admission Record indicated the facility admitted Resident 1 on 8/10/2023 with diagnoses that included thoracic compression fracture, rheumatoid arthritis (a disease that causes severe inflammation of the joints) and acute kidney failure (occurs when the kidneys suddenly become unable to filter waste products from the blood). A review of Resident 1's Minimum Data Set (MDS - a standardized assessment and care-planning tool) dated 11/17/2023, indicated Resident 1 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) and needed total assistance from staff for toileting hygiene, maximum assistance from staff for lower body dressing, and moderate assistance for mobility (movement). A review of Resident 1's Physician's Order dated 9/20/2023 indicated that Resident 1 had an appointment with a spine specialist (a doctor who specializes in the treatment and conditions that affect the spine) on 9/27/2023 at 11:00 a.m. A review of Resident 1's Radiology Order dated 9/27/2023 indicated that Resident 1's spine specialist ordered to obtain an MRI on Resident 1's lumbar and thoracic area without contrast (a chemical that helps show the condition of organs and blood vessels clearly) due to Resident 1's diagnosis of lumbar and thoracic compression fracture. A review of Resident 1's Order Summary Report dated 10/12/2023 indicated that Resident 1 had an MRI appointment on 10/31/2023 at 3:50 p.m. During an interview and concurrent record review with Registered Nurse 1 (RN 1) on 6/20/2024 at 2:38 p.m., RN 1 reviewed Resident 1's Radiology Order dated 9/27/2023 and Progress Notes from 9/27/2023 through 10/12/2023 and stated that the facility did not arrange the MRI appointment for Resident 1's lumbar and thoracic area ordered on 9/27/2023 until Family 1 (FM 1) called. The facility arranged Resident 1's lumbar and thoracic MRI appointment on 10/12/2023 and scheduled for 10/31/2023 at 3:50 p.m. (continued on next page)

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Nursing (DON) on 6/20/2023 at 5:00 p.m., the DON stated that the facility should have made arrangements for Resident 1's radiology services as soon as the orders were received from the attending physician (the primary physician who is responsible for managing the resident's medical care). The DON further stated that the licensed nurses should have notified Resident 1's attending physician for any delayed or missed physician orders. A review of the facility's policy and procedure (P&P) titled, Radiology and other Diagnostic Services and Reporting last reviewed on 1/10/2024, indicated, The facility must provide or obtain radiology and other diagnostic services to meet the needs of its resident.