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	04/04/2024

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** 48678 Based on interview and record review, the facility failed to protect one of three sampled residents' (Resident 70) personal belongings upon the resident's discharge to the General Acute Care Hospital (GACH) This deficient practice resulted in the loss of Resident 70's pants, shirts, socks, and phone charger without reimbursement from the facility. Findings: A review of Resident 70's Admission Record, indicated Resident 70 was originally admitted to the facility on [DATE]. The resident was then readmitted on [DATE] with a diagnosis of basal cell carcinoma of skin (skin cancer). A review of Resident 70's History & Physical, dated 1/30/2024, indicated Resident 70 had the capacity to understand and make decisions. A review of Resident 70's Minimum Data Set (MDS, a comprehensive standardized assessment and screening tool) dated 2/27/2024 indicated Resident 70 had intact cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). The MDS indicated Resident 70 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) on staff for eating and toileting. The MDS further indicated that Resident 70 required maximal assistance (helper does more than half the effort to lift or hold trunk [body] or limbs [arms or legs] and provides more than half the effort) to shower, lower body dressing, putting on and taking off footwear; and mobility (ability to move) from staff. A review of Resident 70's Resident's clothing and Possessions form dated 11/18/2023, indicated Resident 70 had the following items upon admission: a. six shirts b. one slack (pants) c. four pairs of socks (continued on next page)

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	d. one set of eyeglasses e. one electric blanket f. Cell phone g. Charger A review of Resident 70's Resident's clothing and Possessions form dated 1/21/2024, indicated Resident 70 was discharged with the following items inventoried and held at the facility: a. four shirts b. three slacks c. one pair of socks d. one set of eyeglasses e. one electric blanket f. Cell phone During an interview on 4/2/2024 at 9:23 AM in Resident 70's room, Resident 70 stated he noticed he was missing clothing items when he came back to the facility from the GACH on 1/29/2024. Resident 70 stated he noticed he was missing a gray sweater, , some socks, and an electric blanket. Resident 70 stated d he reported the missing items to facility staff. Resident 70 stated that the only item that was replaced by the facility was his electric blanket. Resident 70 stated that it has been two months since he reported the incident of missing belongings, and the facility has still not replaced his missing items. During an interview on 4/2/24 at 2:14 PM with the Social Services Director (SSD), the SSD stated the facility documents all items brought in by residents on the residents clothing and possessions form. The SSD then stated that a resident's belongings are again inventoried upon discharge. The SSD stated when Resident 70 was discharged to the GACH on 1/21/2024, Resident 70's belongings were removed from the resident's room. SSD stated she was not sure where the belongings were stored. SSD stated that upon Resident 70's return to the facility on [DATE], the resident had verbalized that he was missing some of his personal belongings. The SSD stated the facility had replaced Resident 70's electric blanket but was still unable to find the resident's other missing items. The SSD stated if any resident items listed on the inventory form go missing, the facility will replace them if not found, and or reimburse the residents for their loss. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy and procedure titled Theft and Loss Program dated 12/19/2022, indicated, when a personal property item is reported missing, the staff should immediately begin a search for the missing property. If the property is not found, a Theft and Loss report should be completed. The facility is responsible to replace or reimburse the cost of the lost or stolen personal property with a value of 25 dollars or more .

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. 49252 Based on interview and record review, the facility failed to ensure one of two sampled residents (Resident 71) and/or responsible party (RP) the right to be informed of in advance of the risks and benefits of a psychoactive medication (medications capable of affecting the mind, emotions, and behavior), Depakote (mood stabilizer medication), when the medication order was documented incorrectly on informed consent forms. This failure resulted in a violation of Resident 71's and their responsible party's right to make an informed decision regarding the use of a psychoactive medication. Findings: A review of Resident 71's Admission Record indicated the facility readmitted the resident on 2/6/2024 with diagnoses that included metabolic encephalopathy (problem in the brain caused by a chemical imbalance in the blood), dementia (decline in memory or other thinking skills severe enough to reduce a person's ability to perform everyday activities), and psychosis (a severe mental condition in which thought and emotions are so affected that contact is lost with external reality). It also indicated Resident 71's responsible party was a family member. A review of Resident 71's History and Physical (H&P - a formal assessment of a patient and their problem) dated 12/1/2023, indicated Resident 71 did not have the capacity to understand and make decisions. A review of Resident 71's Minimum Data Set (MDS, a standardized resident assessment and care screening tool) dated 2/9/2024, indicated Resident 71 had severely impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). A review of Resident 71's physician's orders, dated 12/20/2023, indicated an order for Depakote oral tablet delayed release 125 milligrams (mg, a unit of measurement), give one tablet by mouth one time a day and give two tablets (250 mg) by mouth in the afternoon, and give two tablets (250 mg) at bedtime for mood disorder manifested by anger outbursts. During a concurrent interview and record review on 4/4/2024 at 2:09 p.m., with the Director of Nursing (DON), reviewed Resident 71's physician order for Depakote, dated 1/9/2024 against the Facility Verification of Informed Consent, undated, and the Physician Documentation of Informed Consent, undated. The Facility Verification of Informed Consent, undated, and the Physician Documentation of Informed Consent, undated, indicated Depakote 125 mg daily, 150 mg every afternoon, and 150 mg every evening to be given for mood disorder manifested by anger outbursts. The DON stated the Depakote orders on the informed consents were written wrong and the RP would not be fully informed of what the resident was getting because it didn't match the physician order. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure titled, Informed Consent, revised 3/25/2024, indicated, It is the policy of this facility to uphold the rights of residents to participate in the planning and decision-making process concerning their care and treatment .the facility will verify that informed consent has been obtained prior to any medical intervention or treatment is initiated, including, but not limited to, administration of psychotherapeutic medications . During a review of the facility's policy and procedure titled, Documentation in Medical Record dated 12/19/2022, indicated Documentation shall be accurate, relevant, and complete .

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 38469 Based on interview and record review, the facility failed to develop a baseline care plan (a written document that summarizes a patient's needs, goals, and care) within 48 hours of admission for one of one sampled resident (Resident 82) investigated under anticoagulant (medication that stops your blood from clotting too easily) use. This deficient practice had the potential to result in a negative impact on residents' health and safety, as well as the quality of care and services received. Findings: A review of Resident 82's Face Sheet (admission record) indicated the facility originally admitted the resident on 2/6/2024 and readmitted the resident on 3/18/2024, with diagnoses including dementia (decline in memory or other thinking skills severe enough to reduce a person's ability to perform everyday activities), gastro-esophageal reflux disease (stomach contents flow backward, up into the esophagus, the tube that carries food from your throat into stomach) and chronic obstructive pulmonary disease (COPD - a chronic lung disease that makes it difficult to breathe). A review of Resident 82's History and Physical (H&P - a formal assessment of a patient and their problem) dated 3/21/2024 indicated that the resident had the capacity to understand and make decisions. A review of Resident 82's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 2/13/2024, indicated that the resident's cognitive (thought processes) skills for daily decision making was intact and the resident required maximal assistance with eating, oral hygiene, upper body dressing and personal hygiene. A review of Resident 82's physician's orders dated 3/18/2024 indicated an order for apixaban (anticoagulant) oral tablet five (5) milligram (mg, a unit of measurement), one tablet by mouth two times a day for atrial fibrillation (an irregular and often very rapid heart rhythm). During a concurrent interview and record review on 4/3/2024 at 8:50 a.m. with Registered Nurse Supervisor 1 (RNS1), reviewed Resident 82's physician's admission orders which included an order for apixaban on 3/18/2024 and Resident 82's Care Plan for Anticoagulant Therapy related to Atrial Fibrillation dated 4/1/2024. RNS 1 stated the baseline care plan must be initiated within 48 hours of admission. RNS 1 stated that if there is no baseline care plan developed, then there would not be interventions in placed to prevent bleeding which could result to hemorrhage and can be life threatening. A review of the facility's policy and procedure titled, High Risk Medications-Anticoagulants, last reviewed on 1/10/2024, indicated, This policy addresses the facility's collaborative, systematic approach to managing anticoagulant therapy for efficacy and safety .the resident's plan of care shall include interventions to minimize risk of adverse consequences . (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure titled, Baseline Care Plan, last reviewed on 1/10/2024, indicated, The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care .the baseline care plan will be developed within 48 hours of a resident's admission .

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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. 48678 Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan (a form where licensed nurses can summarize a person's health conditions, specific care needs, and current treatments) for one of four sampled residents (Resident 46) for a diagnosis of diabetes mellitus (DM, a chronic condition that affects the way the body processes blood glucose [sugar]). This deficient practice had the potential to negatively affect the delivery of care and services to Resident 46. Findings: A review of Resident 46's Admission Record indicated the facility admitted the resident on 2/7/2024 with diagnosis of DM. A review of Resident 46's History & Physical (H&P - a formal assessment of a patient and their problem) dated 2/9/2024, indicated that Resident 46 has DM. A review of Resident 46's Minimum Data Set (MDS- a standardized assessment and screening tool) dated 2/22/2024, indicated Resident 46 had severely impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). The MDS also indicated Resident 46 had an active diagnosis of DM. The MDS indicated Resident 46 required insulin (hormone that lowers the level of glucose in the blood) administration. A review of Resident 46's physician's orders dated 2/7/2024, indicated an order to inject 10 units (U, a unit of measurement) insulin glargine (long-acting insulin) subcutaneously (under the skin) at bedtime for DM rotate injection site. Hold if blood sugar is less than 100. During a concurrent interview and record review on 4/3/2024 at 4 p.m., with Licensed Vocational Nurse 1 (LVN 1), reviewed Resident 46's care plans from 2/7/2024 to 4/3/2024. LVN 1 stated Resident 46 did not have a specific care plan for his diagnosis of DM. LVN 1 stated there were orders for administration of insulin to treat Resident 46's DM and that is what he used to guide his care for treating Resident 46's DM. LVN 1 stated that Resident 46 had a care plan for limited mobility and his diagnosis of DM was listed under this section, but there were no specific interventions for treating Resident 46's DM. During a concurrent interview and record review on 4/4/2024 at 11:03 a.m., with the Director of Nursing (DON), reviewed Resident 46's care plans from 2/7/2024 to 4/3/2024. The DON stated the licensed nurses are responsible for initiating a care plan for residents within 48 hours of admission and update the care plan if any changes with residents occur. The DON stated that upon review of Resident 46's care plans, the licensed nurses did not develop a care plan for Resident 46's DM. The DON stated Resident 46 should have a care plan so that specific interventions such as diet and medications can be monitored. The DON stated every resident needs to have a care plan to support the plan for residents. (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 procedures titled, Comprehensive Care Plans, dated 12/9/2022, indicated, the comprehensive care plan will be developed within seven (7) days after the completion of the comprehensive MDS assessment. All Care Assessment Areas (CAAs) triggered by the MDS will be considered in developing the plan of care.

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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** 49252 Based on interviews and record review, the facility failed to ensure that Medical Doctor 1 (MD 1) signed the physician orders for one of three sampled residents (Resident 71) during MD 1's visit to the facility. This deficient practice had the potential for confusion, poor continuity of care and follow-up on the resident's status. Findings: A review of Resident 71's Admission Record, dated 4/3/2024, indicated the resident was readmitted to the facility on [DATE] with diagnoses that included metabolic encephalopathy (brain dysfunction caused by diseases or toxins in the body), dementia (progressive impaired ability to think, remember or make decisions that interferes with doing everyday activities) and psychosis (a severe mental condition in which thought and emotions are so affected that contact is lost with external reality). The admission record indicated Resident 71's primary physician as MD 1. A review of Resident 71's History and Physical (H&P- a term used to describe a physician's examination of a resident) dated 12/1/2023, the H&P indicated, Resident 71 did not have the capacity to understand and make decisions. During a review of Resident 71's Minimum Data Set (MDS, a standardized resident assessment and care screening tool) assessment dated [DATE], the MDS indicated Resident 71 had severely impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). A review of Resident 71's Physician order dated 2/2/2024 indicated an order to transfer Resident 71 to the General Acute Care Hospital (GACH) for further revaluation due to continued poor oral intake. The order was not signed and dated by the MD 1. During an interview on 4/4/2024 at 11:09 a.m. with Licensed Vocational Nurse 4 (LVN 4), LVN 4 stated that MD 1 last visited the facility on 3/22/2024. During a concurrent interview and record review on 4/4/2024 at 1:37 p.m. with Director of Nursing (DON), Resident 71's physician order, dated 2/2/2024 for Resident 71's transfer to the GACH for poor oral intake was reviewed. DON stated that there was no signature and date by MD 1 on Resident 71's physician order dated 2/2/2024 for transfer to the GACH for poor oral intake. DON stated that all unsigned physician orders should be signed and dated by the physician during their next visits to the facility. the DON stated that unfortunately, physicians are inconsistent with signing their orders for residents during their visits. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure titled, Documentation in Medical Record, dated 12/19/2022, indicated Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy .Principles of documentation include, but are not limited to: Documentation shall be timely .Sign each entry with name and credentials of the person making the entry.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34659 Based on interview and record review, the facility failed to: 1. Ensure licensed nurses signed one of six sampled resident's (Resident 49) Medication Administration Record (MAR- a report detailing the medications administered to a resident by a healthcare professional) for 3/2024 after administering Hydrocodone-Acetaminophen (Norco- medication that treats pain) and Alprazolam (medication to treat anxiety [feeling of uneasiness]) to the resident. 2. Ensure licensed nurses signed one of six sampled resident's (Resident 65) MAR for 3/2024 after administering Lorazepam (medication for anxiety) 0.5 mg to the resident. 3. Ensure licensed nurses signed one of six sampled resident's (Resident 139) MAR for 3/2024 after administering zolpidem tartrate (a medication given to treat insomnia) 10 mg to the resident. 4. Ensure the controlled medication (a type of medication with a high potential for abuse) Norco was disposed rather than placing it back into the bubble pack (plastic packaging in which a medication is stored until ready for use) after it has been removed and securing it with tape for one of six sampled residents (Resident 84). 5. Ensure that the licensed nurse followed the facility policy and procedure of medication administration by signing the MAR immediately after the administration of the controlled medication oxycodone hydrochloride (oxycodone HCL-medication for pain) to one of six sampled residents (Resident 70) immediately administering the medication to the resident. These deficient practices had the potential to result in unidentified controlled medication loss and increased the risk for drug diversion (transfer of a medication from a legal to an illegal use). Findings: 1. A review of Resident 49's Face Sheet indicated the resident was admitted to the facility on [DATE] with diagnoses that included pos-traumatic stress disorder (a condition of persistent mental and emotional stress occurring as a result of injury, typically involving disturbance of sleep and constant vivid recall of the experience). A review of Resident 49' s Minimum Data Set (MDS a standardized assessment and screening tool) dated 3/01/2024, indicated Resident 49 was cognitively (the process of acquiring knowledge and understanding through thought, experience, and the senses) intact with skills required for daily decision making. The MDS indicated Resident 49 required supervision (helper provides verbal cues and/or touching assistance with completing an activity) with eating, toileting, and dressing. A review of Resident 49's Physician's Orders indicated an order for the following: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a) Norco 5-325 milligrams (mg, a unit of measure), give one tablet by mouth every four hours as needed for moderate pain five to seven (on the numeric scale with zero being no pain and 10 being the most excruciating pain imaginable), dated 2/21/2024. b) Alprazolam 0.5 mg tablet, give one tablet by mouth every six hours as needed for anxiety, dated 3/11/2024. A review of Resident 49's Controlled Drug Record (CDR- a record of the administer control drugs to a resident by a healthcare professional in a facility) indicated the medication Norco 5-325mg was removed from the bubble pack on the following dates and times: i. 3/16/2024 at 3 p.m. ii. 3/17/2024 at 1 a.m. iii. 3/18/2024 at 12 p.m. iv. 3/19/2024 at 5 p.m. v. 3/20/2024 at 11 p.m. vi. 3/21/2024 at 11 p.m. vii. 3/23/2024 at 4 a.m. viii. 3/23/2024 at 10:15 p.m. ix. 3/26/2024 at 4 p.m. x. 3/26/2024 at 11 p.m. xi. 3/27/2024 at 11 p.m. xii. 3/30/2024 at 10 p.m. A review of Resident 49's CDR indicated the medication Alprazolam 0.5mg was removed from the bubble pack on the following dates and times: i. 3/16/2024 at 9 p.m. ii. 3/17/2024 at 9 p.m. iii. 3/19/2024 at 10 p.m. iv. 3/20/2024 at 10 p.m. v. 3/21/2024 at 10 p.m. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	vi. 3/23/2024 at 10 p.m. vii. 3/26/2024 at 10 p.m. viii. 3/27/2024 at 11 p.m. ix. 3/28/2024 at 11 p.m. x. 3/29/2024 at 9 p.m. xi. 3/30/2024 at 4 a.m. xii. 3/30/2024 at 10 p.m. xiii. 3/31/2024 at 9 p.m. A review of Resident 49's Medication Administration Record (MAR) for the month of 3/2024 indicated that there was no licensed nurse's documentation that Norco 5-325 was administered on the following dates: i. 3/16/2024 at 3 p.m. ii. 3/17/2024 at 1 a.m. iii. 3/18/2024 at 12 p.m. iv. 3/19/2024 at 5 p.m. v. 3/20/2024 at 11 p.m. vi. 3/21/2024 at 11 p.m. vii. 3/23/2024 at 4 a.m. viii. 3/23/2024 at 10:15 p.m. ix. 3/26/2024 at 4 p.m. x. 3/26/2024 at 11 p.m. xi. 3/27/2024 at 11 p.m. xii. 3/30/2024 at 10 p.m. A review of Resident 49's Medication Administration Record (MAR) for the month of 3/2024 indicated that there was no licensed nurse's documentation that Alprazolam 0.5mg was administered on the following dates: (continued on next page)

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

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	i. 3/16/2024 at 9 p.m. ii. 3/17/2024 at 9 p.m. iii. 3/19/2024 at 10 p.m. iv. 3/20/2024 at 10 p.m. v. 3/21/2024 at 10 p.m. vi. 3/23/2024 at 10 p.m. vii. 3/26/2024 at 10 p.m. viii. 3/27/2024 at 11 p.m. ix. 3/28/2024 at 11 p.m. x. 3/29/2024 at 9 p.m. xi. 3/30/2024 at 4 a.m. xii. 3/30/2024 at 10 p.m. xiii. 3/31/2024 at 9 p.m. During a concurrent interview and record review with Licensed Vocational Nurse 1 (LVN 1) on 4/01/2024 at 3:55 p.m., reviewed Resident 49's MAR for 3/2024 and CDR for Norco 5-325mg and Alprazolam 0.5mg After reviewing Resident 49's MAR for 3/2024 and CRD for both Norco 5-325 mg and Alprazolam 0.5mg, LVN 1 stated that there was no corresponding nurse documentation in Resident 49's MAR that Norco 5-325mg was administer on the following date: i. 3/16/2024 at 3 p.m. ii. 3/17/2024 at 1 a.m. iii. 3/18/2024 at 12 p.m. iv. 3/19/2024 at 5 p.m. v. 3/20/2024 at 11 p.m. vi. 3/21/2024 at 11 p.m. vii. 3/23/2024 at 4 a.m. viii. 3/23/2024 at 10:15 p.m. (continued on next page)

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ix. 3/26/2024 at 4 p.m. x. 3/26/2024 at 11 p.m. xi. 3/27/2024 at 11 p.m. xii. 3/30/2024 at 10 p.m. LVN 1 further stated that there was no corresponding nurse documentation in Resident 49's MAR that Alprazolam 0.5mg was administer on the following date: i. 3/16/2024 at 9 p.m. ii. 3/17/2024 at 9 p.m. iii. 3/19/2024 at 10 p.m. iv. 3/20/2024 at 10 p.m. v. 3/21/2024 at 10 p.m. vi. 3/23/2024 at 10 p.m. vii. 3/26/2024 at 10 p.m. viii. 3/27/2024 at 11 p.m. ix. 3/28/2024 at 11 p.m. x. 3/29/2024 at 9 p.m. xi. 3/30/2024 at 4 a.m. xii. 3/30/2024 at 10 p.m. xiii. 3/31/2024 at 9 p.m. LVN 1 stated that licensed nurses should sign both the CDR and MAR of a resident when administered controlled drug medications. LVN 1 stated that this was not done for Resident 49. During a concurrent interview and record review with the Director of Nurses (DON) on 4/02/2024 at 2:20 p.m. , reviewed Resident 49's Norco 5-325mg and Alprazolam 0.5mg CDRs and 3/2024 MAR. The DON stated the process for administering a controlled drug to a resident is to remove the medication from the package, sign out the medication on the CDR, administer the medication to the resident and to sign the MAR. The DON stated this is important to keep an accurate count of the medication to prevent drug diversion. (continued on next page)

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 65's Face Sheet indicated the resident was admitted to the facility on [DATE] with diagnoses that included anxiety disorder. A review of Resident 65' s MDS, dated [DATE], indicated Resident 65 was moderately impaired in cognition with skills required for daily decision making. The MDS indicated Resident 65 required setup assistance (helper sets us and resident completes activity) with eating, toileting, and dressing. A review of Resident 65's Physician's Orders indicated an order for Lorazepam 0.5 mg tablet, give one tablet by mouth every eight hours as needed for anxiety, dated 3/14/2024. A review of Resident 65's Care Plan for Anxiety, initiated 9/03/2023, indicated a goal that the resident will be free from discomfort or adverse reactions related to anti-anxiety therapy through the review date. The care plan indicated to administer Lorazepam as ordered by the physician. A review of Resident 65's CDR indicated the medication Lorazepam 0.5mg was removed from the bubble pack on the following dates and times: i. 3/15/2024 at 6 p.m. ii. 3/16/2024 at 10 a.m. iii. 3/19/2024 at 10:30 a.m. iv. 3/22/2024 at 2 p.m. v. 3/23/2024 at 11 a.m. vi. 3/24/2024 at 7 p.m. vii. 3/27/2024 at 7 p.m. viii. 3/26/2024 at 1 p.m. ix. 3/27/2024 at 11 a.m. x. 3/28/2024 at 10:30 a.m. xi. 3/29/2024 at 10:45 a.m. xii. 3/29/2024 at 8 p.m. xiii. 3/30/2024 at 10 a.m. xiv. 3/31/2024 at 10:30 a.m. xv. 3/31/2024 at 7 p.m. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 65's Medication Administration Record (MAR) for the month of 3/2024 indicated the medication Lorazepam was not administered on any of the following dates: i. 3/15/2024 at 6 p.m. ii. 3/16/2024 at 10 a.m. iii. 3/19/2024 at 10:30 a.m. iv. 3/22/2024 at 2 p.m. v. 3/23/2024 at 11 a.m. vi. 3/24/2024 at 7 p.m. vii. 3/27/2024 at 7 p.m. viii. 3/26/2024 at 1 p.m. ix. 3/27/2024 at 11 a.m. x. 3/28/2024 at 10:30 a.m. xi. 3/29/2024 at 10:45 a.m. xii. 3/29/2024 at 8 p.m. xiii. 3/30/2024 at 10 a.m. xiv. 3/31/2024 at 10:30 a.m. xv. 3/31/2024 at 7 p.m. During a concurrent interview and record review with Licensed Vocational Nurse 2 (LVN 2) on 4/02/2024 at 1:34 p.m., reviewed Resident 65's Controlled Drug Record for Lorazepam 0.5mg and MAR for 3/2024. LVN 2 stated that there was no corresponding licensed nurse's documentation in Resident 65's MAR that indicated the resident received Lorazepam 0.5mg on the following dates: i. 3/15/2024 at 6 p.m. ii. 3/16/2024 at 10 a.m. iii. 3/19/2024 at 10:30 a.m. iv. 3/22/2024 at 2 p.m. v. 3/23/2024 at 11 a.m. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	vi. 3/24/2024 at 7 p.m. vii. 3/27/2024 at 7 p.m. viii. 3/26/2024 at 1 p.m. ix. 3/27/2024 at 11 a.m. x. 3/28/2024 at 10:30 a.m. xi. 3/29/2024 at 10:45 a.m. xii. 3/29/2024 at 8 p.m. xiii. 3/30/2024 at 10 a.m. xiv. 3/31/2024 at 10:30 a.m. xv. 3/31/2024 at 7 p.m. LVN 2 stated the licensed nurses should have signed the MAR after giving Resident 65 the medication Lorazepam 0.5mg. During a concurrent interview and record review with the Director of Nurses (DON) on 4/02/2024 at 2:20 p.m. , reviewed Resident 65's Lorazepam 0.5mg CDR and 3/2024 MAR. The DON stated the process for administering a controlled drug to a resident is to remove the medication from the package, sign out the medication on the CDR, administer the medication to the resident and then sign the MAR. The DON stated this is important to keep an accurate count of the medication to prevent drug diversion. 3. A review of Resident 139's Face Sheet indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included insomnia (inability to sleep). A review of Resident 139' s MDS, dated [DATE], indicated Resident 139 was cognitively intact with skills required for daily decision making. The MDS indicated Resident 65 required supervision with eating, toileting, and dressing. A review of Resident 139's Physician's Orders indicated an order for Zolpidem Tartrate 10 mg tablet, give one tablet by mouth every 24 hours at bedtime as needed for insomnia, dated 3/14/2024. A review of Resident 139's Controlled Drug Record indicated the medication Zolpidem 10mg was removed from the bubble pack on the following dates and times: i. 3/29/2024 at 9 p.m. ii. 3/30/2024 at 9 p.m. iii. 3/31/2024 at 10:30 p.m. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 139's Medication Administration Record (MAR) for the month of 3/2024 indicated the medication Zolpidem 10mg was not administered on: i. 3/29/2024 at 9 p.m. ii. 3/30/2024 at 9 p.m. iii. 3/31/2024 at 10:30 p.m. During a concurrent interview and record review with LVN 2 on 4/02/2024 at 1:34 p.m., reviewed Resident 139's Controlled Drug Record for Zolpidem 10 mg and MAR for 3/2024. LVN 2 stated that there was no corresponding licensed nurse's documentation in Resident 139's MAR that indicated the resident received Zolpidem 10 mg on the following dates: i. 3/29/2024 at 9 p.m. ii. 3/30/2024 at 9 p.m. iii. 3/31/2024 at 10:30 p.m. LVN 2 stated the licensed nurses should have signed the MAR after giving Resident 139 the medication Zolpidem 10mg. During a concurrent interview and record review with the Director of Nurses (DON) on 4/02/2024 at 2:20 p.m. , reviewed Resident 139's Zolpidem 10 mg CDR and 3/2024 MAR. The DON stated the process for administering a controlled drug to a resident is to remove the medication from the package, sign out the medication on the CDR, administer the medication to the resident and then sign the MAR. The DON stated this is important to keep an accurate count of the medication to prevent drug diversion. A review of the facility's policy and procedure titled, Controlled Substance Administration & Accountability, last reviewed 1/10/2024, indicated controlled substances (Schedule II, III, IV, V, drugs that are subject to high levels of regulation as a result of government decisions about those drugs that are especially addictive and harmful) are recorded on the Controlled Drug Record. The policy and procedure indicated, the Controlled Drug Record is a permanent medical record document and in conjunction with the MAR is the source of documenting any resident-specific narcotic dispensed from the pharmacy. A review of the facility's policy and procedure titled, Medication Administration, last reviewed 1/10/2024, indicated the MAR is to be signed after administering the medication. 4. A review of Resident 84's Face Sheet indicated the resident was admitted to the facility on [DATE] with diagnoses that included right calcaneus fracture (right heel fracture). A review of Resident 84' s MDS, dated [DATE], indicated Resident 84 was moderately impaired in cognition with skills required for daily decision making. The MDS indicated Resident 84 required supervision with eating and maximum assistance (helper does more than half the effort) with toileting and dressing. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 84's Physician's Orders indicated an order for Norco 5-325 mg, give one tablet by mouth every eight hours as needed for severe pain eight out of 10 on a pain scale of 10, dated 2/29/2024. A review of Resident 84's Care Plan for Pain, initiated 3/12/2024, indicated a goal that the resident will verbalize adequate relief of pain. The care plan indicated an intervention to administer analgesia (another term for pain medication). During a concurrent medication cart observation and interview with LVN 1 on 4/01/2024 at 3:55 p.m., observed the station one medication cart. Observed Resident 84's Norco bubble pack. Noted in the bubble pack was one dose of Norco previously removed and was now being secured in place with a clear piece of tape over the packaging. LVN 1 stated that once a medication has been removed, if the medication is not administered, the licensed nurse should dispose of the medication with a witnessed in one of the secured disposable containers. LVN 1 stated that the disposal should then be documented on the residents CDR medication. During an interview with the DON on 4/02/2024 at 2:20 p.m., the DON stated once the medication packaging has been broken the medication should be given or discarded and signed by two licensed nurses. The DON stated she co-signed with LVN 1 on 4/01/2024 and discarded the medication. The DON stated this process is important to ensure accuracy of records and infection control measures are followed. A review of the facility's policy and procedure titled, Controlled Substance Administration & Accountability, last reviewed 1/10/2024, indicated when destroying medications, two licensed staff must witness any disposal or destruction of a controlled substance and document same on the CDR. 48678 5. A review of Resident 70's Admission Record, indicated Resident 70 was originally admitted to the facility on [DATE]. The resident was then readmitted on [DATE] with a diagnosis of basal cell carcinoma of skin (skin cancer). A review of Resident 70's History & Physical, dated 1/30/2024, indicated Resident 70 had the capacity to understand and make decisions. A review of Resident 70's MDS dated [DATE] indicated Resident 70 had intact cognition. The MDS indicated Resident 70 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) on staff for eating and toileting. The MDS further indicated that Resident 70 required maximal assistance (helper does more than half the effort to lift or hold trunk [body] or limbs [arms or legs] and provides more than half the effort) to shower, lower body dressing, putting on and taking off footwear; and mobility (ability to move) from staff. A review of Resident 70's Physician orders dated 1/29/2024, indicated Resident 70 had an order for oxycodone HCL oral solution five milligram per five milliliters (mg/mL-unit of measure) to give via gastrostomy tube (G-tube a tube inserted through the belly that brings nutrition directly to the stomach) ever four hours as needed for pain management for facial carcinoma. A review of the Resident 70's CDR for oxycodone HCL five mg/ml indicated that on 3/31/2024 at 4:00 a.m. a dose of five mg/ml was removed. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 70's MAR for 3/31/2024 indicated that the resident received his scheduled dose of oxycodone HCL five mg/ml on 3/31/2024 at 4:00 a.m. A review of the facility's administration details (a detail record of a resident's MAR that shows the actual time the licensed nurse documented on the form) for Resident 70's Oxycodone HCl five mg/ml with an accessed date of 4/4/2024, indicated that the licensed nurse administered a dose of Resident 70's oxycodone HCL five mg/ml on 3/31/2024 at 4:00 a.m. The form further indicated that the licensed nurse did not document the administration of Resident 70's Oxycodone HCL until 6:01 a.m. on 3/31/2024. During a concurrent interview and record review on 4/4/2024 at 11:17 a.m., with the DON, reviewed Resident 70's MAR for 3/2024 and CDR for Oxycodone HCL five mg/ml dated 3/31/2024. The DON stated that the licensed nurse did not document the administration of Resident 70's scheduled oxycodone HCL five mg/ml that was due at 4:00 a.m. on 3/31/2024 until 6:01 a.m. on 3/21/2024. The DON stated the nurse was two hours late with her documentation of the administration of medication. During an interview on 4/4/2024 at 1:37 p.m. with the DON, the DON stated the risks of not documenting medications immediately after administration is that it can result in discrepancies. A review of the facility's policy and procedure titled, Medication Administration dated 12/19/2022 and last reviewed 1/10/2024, indicated medications are administered by licensed nurses as ordered by the physician and in accordance with professional standards of practice. The policy and procedures compliance guidelines indicates to sign the MAR after administering the medication.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 38469 Based on interview and record review, the facility failed to ensure the Medication Regimen Review (MRR, a monthly thorough evaluation by the consulting pharmacist of a resident's medication regimen, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication) was acted upon for two of five sampled residents (Resident 51 and 12 by failing to: 1. Ensure the pharmacist recommendation on 9/26/2023 to verify duration of therapy of Lovenox (anticoagulant medication [blood thinner]) and consider oral replacement was discussed with the provider and provide a rationale why Lovenox was only discontinued on 12/19/2024 for Resident 51. This deficient practice has placed the resident at an increased risk of experiencing adverse side effects (unwanted undesirable effects that are possibly related to a drug) such as bleeding and pain on injection site during medication administration. 2. Ensure the pharmacy recommendation for a dose reduction of Ambien (can treat insomnia [inability to sleep]) was discussed with the provider and provide a rationale to maintain or reduce the dose for Resident 12. This deficient practice had the potential to result in unnecessary medications and can lead to side effects such as drowsiness, dizziness and blurry vision which could lead to fall. Findings: a. A review of Resident 51's Admission Record indicated the facility admitted the resident on 9/16/2023 with diagnoses including gastro-esophageal reflux disease (stomach contents flow backward, up into the esophagus, the tube that carries food from your throat into stomach) and acute embolism and thrombosis of unspecified deep veins of lower extremity (blood clot [gel-like clump of blood] in leg vein). A review of Resident 51's Minimum Data Set (MDS - an assessment and care screening tool), dated 3/20/2024, indicated the resident's cognitive skills (cognition refers to conscious mental activities, and include thinking, reasoning, understanding, learning, and remembering) for daily decision-making was intact. The MDS further indicated Resident 51 required supervision with eating, oral hygiene, toileting hygiene, upper body dressing, lower body dressing and putting on/taking off footwear. A review of Resident 51's physician's order dated 9/17/2023 indicated an order for enoxaparin sodium (Lovenox) injection prefilled syringe kit 40 milligram (mg, a unit of measurement)/0.4 milliliter (ml, a unit of measurement), inject subcutaneously (beneath the skin) one time a day for deep vein thrombosis (DVT, a blood clot that develops in one of the large veins in the body) prophylaxis (an attempt to prevent disease) and rotate injection sites. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 4/3/2024 at 2:27 p.m., with the Director of Nursing (DON), reviewed Resident 51's Consultant Pharmacist's Medication Regimen Review (CP-MRR) for the month of 9/2023. The DON verified by stating that on 9/26/2023, Resident 51's CP-MRR indicated, Resident has an order for Lovenox 40 mg subcutaneously daily .Please verify duration of therapy for use of this medication, consider oral replacement, if possible, or please document rationale for continuing with this medication at this time. The DON also verified by stating that Resident 51's CP-MRR had a written marginal note which indicated Done, medication (med) discontinued (d/c) changed to Eliquis (anticoagulant medication),. The DON stated that the recommendation to verify duration of Lovenox and consider oral replacement was not acted upon as there was no documented progress note that this recommendation was discussed with the physician. The DON stated that the purpose of the CP-MRR is to identify if there are unnecessary medications that the resident is taking and to minimize resident from having adverse effects from their medications. The DON stated that Lovenox can increase the risk of bleeding that could lead to hemorrhage (bleeding) and death. The DON stated that Lovenox is administered via injection which is painful for the resident. The DON stated that based on Resident 51's Medication Administration Record (MAR- used to document medications taken by each individual), Resident 51 received Lovenox injection from 9/17/2023 to 12/19/2023. A review of Resident 51's physician's orders dated 12/19/2023, indicated an order to discontinue Lovenox and start Eliquis (used to treat and prevent blood clots) 2.5 mg by mouth two times a day. A review of the facility's policy and procedure titled, High Risk Medications-Anticoagulants, last reviewed on 1/10/2024, indicated, This facility recognizes that some medications, including anticoagulants are associated with greater risks of adverse consequences than other medications. This policy addresses the facility's collaborative, systematic approach to managing anticoagulant therapy for efficacy and safety .the resident's plan of care shall include interventions to minimize risk of adverse consequences . A review of the facility's policy and procedure titled, Medication Regimen Review, last reviewed on 1/10/2024, indicated, The drug regimen of each resident is reviewed at least once a month by a licensed pharmacist and includes a review of the resident's medical chart .the Medication Regimen Review (MRR) is a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with the medication .Facility staff shall act upon all recommendations according to procedures for addressing medication regimen review irregularities. b. A review of Resident 12's Admission Record indicated the facility admitted the resident on 6/1/2023 with diagnoses that included muscle weakness, type two (2) diabetes mellitus (a chronic condition that affects the way the body processes blood glucose [sugar]), and hypertension (high blood pressure [the force of the blood pushing on the blood vessel walls is too high]). A review of Resident 12's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 2/7/2024, indicated the resident's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was intact and the resident was dependent on staff for toileting hygiene, shower, lower body dressing and putting on/taking off footwear. (continued on next page)

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 12's physician's orders dated 6/8/2023, included Ambien oral tablet five (5) milligrams (mg, a unit of measurement) one tablet by mouth at bedtime for insomnia manifested by inability to sleep. During a concurrent interview and record review on 4/3/2024 at 4:11 p.m., with the Director of Nursing (DON), reviewed Resident 12's Consultant Pharmacist's Medication Regimen Review (CP-MRR) for the month of 9/2023. Resident 12's CP-MRR dated 9/26/2023, indicated a note by the consultant pharmacist that indicated, Resident has been taking Ambien 5 mg at bedtime for insomnia since 6/2023. Please consider a dose reduction, with eventual goal of discontinuation, or document that doses reduction is not indicated at this time in this resident. The DON stated that there was no follow-up and no documentation that the recommendation for Ambien 5 mg was discussed with the provider. The DON stated that the purpose of the CP-MRR is to identify if there are unnecessary medications that the resident is taking and to minimize resident from having adverse effects from their medications such as drowsiness that can lead to fall and injury. A review of the facility's policy and procedure titled, Medication Regimen Review, last reviewed on 1/10/2024, indicated, The drug regimen of each resident is reviewed at least once a month by a licensed pharmacist and includes a review of the resident's medical chart .the Medication Regimen Review (MRR) is a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with the medication .Facility staff shall act upon all recommendations according to procedures for addressing medication regimen review irregularities. A review of the facility's policy and procedure titled, Use of Psychotropic (medications capable of affecting the mind, emotions, and behavior) Medication, last reviewed on 01/10/2024, indicated, Residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition, as diagnosed and documented in the clinical record, and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication .residents who use psychotropic drugs shall receive gradual dose reduction, unless clinically contraindicated, in an effort to discontinue these drugs .

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 34659 Based on interview and record review, the facility failed to monitor a resident's behaviors for all nursing shifts, who was prescribed an antipsychotic medication (medications used to treat psychosis [a mental condition in which thought, and emotions are so affected that contact is lost with external reality]) for one of five sampled residents (Resident 46) investigated for unnecessary medications. This deficient practice had the potential to result in adverse reaction (undesired harmful effect resulting from a medication or other intervention) or impairment in the resident's mental or physical condition. Findings: A review of Resident 46's Admission Record indicated the facility admitted the resident on 2/3/2022 with diagnoses that included schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly). A review of Resident 46's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 2/2/2024, indicated Resident 46 was severely impaired in cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) with skills required for daily decision making. The MDS indicated Resident 46 was dependent (helper does all the effort) with toileting, dressing and personal hygiene. A review of Resident 46's physician's orders indicated the following: - Zyprexa tablet (brand name for an antipsychotic medication), give 7.5 milligrams (mg, a unit of measure) by mouth at bedtime for schizophrenia manifested by auditory (hearing) and visual (seeing) hallucination (seeing or hearing things that are not there), dated 2/7/2024. - Zyprexa tablet, give five (5) mg by mouth one time a day for schizophrenia manifested by auditory and visual hallucination dated 9/17/2022 and discontinued 2/7/2024. - Zyprexa tablet, give 7.5 mg by mouth at bedtime for schizophrenia manifested by auditory and visual hallucination, dated 2/10/2023 and discontinued 2/7/2024. A review of Resident 46's Care Plan for Antipsychotic Medication, initiated 9/17/2022, indicated Resident 46 takes Zyprexa for visual and auditory hallucinations. The care plan indicated a goal that Resident 46 will reduce the use of psychotropic medication through the review date. The care plan indicated a goal to monitor/record occurrence of target behavior (a specific measurable behavior that has been selected to be changed) and document per facility protocol. A review of Resident 46's Medication Administration Records (MAR, a legal record of the drugs administered to a patient at a facility) indicated the following: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- For the 11/2023 MAR, there was behavior monitoring for Zyprexa for the 7 a.m. to 3 p.m. shift and 3 p.m. to 11 p.m. shift but no monitoring for the 11 p.m. to 7 a.m. shift from 11/1/2023 to 11/30/2023. - For the 12/2023 MAR, there was behavior monitoring for Zyprexa for the 7 a.m. to 3 p.m. shift and 3 p.m. to 11 p.m. shift but no monitoring for the 11 p.m. to 7 a.m. shift from 12/1/2023 to 12/31/2023. - For the 1/2024 MAR, there was behavior monitoring for Zyprexa for the 3 p.m. to 11 p.m. shift but no monitoring for the 11 p.m. to 7 a.m. shift or the 7 a.m. to 3 p.m. shift from 1/1/2024 to 1/31/2024. - For the 2/2024 MAR, there was behavior monitoring for Zyprexa for the 3 p.m. to 11 p.m. shift but no monitoring for the 11 p.m. to 7 a.m. shift or the 7 a.m. to 3 p.m. shift from 2/1/2024 to 2/29/2024. - For the 3/2024 MAR, there was behavior monitoring for Zyprexa for the 3 p.m. to 11 p.m. shift but no monitoring for the 11 p.m. to 7 a.m. shift or the 7 a.m. to 3 p.m. shift from 3/1/2/24 to 3/31/2024. - For the 4/2024 MAR, there was behavior monitoring for Zyprexa for the 3 p.m. to 11 p.m. shift but no monitoring for the 11 p.m. to 7 a.m. shift or the 7 a.m. to 3 p.m. shift from 4/1/2024 to 4/3/2024. During a concurrent interview and record review on 4/4/2024 at 1:35 p.m., with Licensed Vocational Nurse 3 (LVN 3), reviewed Resident 46's MAR dated 3/2024. LVN 3 verified by stating that there was no behavior monitoring for Resident 46's use of Zyprexa for the 7 a.m. to 3 p.m. shift and the 11 p.m. to 7 a.m. shift for Resident 46's MAR dated 3/2024. LVN 3 stated there should be behavior monitoring for Resident 46 for all shifts. LVN 3 stated she works the 11 p.m. to 7 a.m. shift. LVN 3 stated Resident 46 has behaviors for which he is given Zyprexa but was unable to show any documentation of the behaviors she observes. LVN 3 stated it is important to monitor the behaviors for the use of Zyprexa so the licensed nurses can assess if the medication was effective and if not, the resident's physician could be notified to make any changes in dosage. LVN 3 stated behavior monitoring for all shifts is important so that there is a correct calculation to determine if a gradual dose reduction (reducing a medication gradually because the medication is effective in treating targeted behaviors) can be conducted. During a concurrent interview and record review on 4/4/2024 at 2:37 p.m., with the Director of Nursing (DON), reviewed Resident 46's MARs dated 11/2023 through 4/2024. The DON verified by stating that there was no behavior monitoring for Resident 46's use of Zyprexa for all three shifts for the 11/2023, 12/2023, 1/2024, 2/2024, and 3/2024 MARs, but was only monitored only during the shift in which the medication, Zyprexa, was being given. The DON stated the corporate office does not specify who monitors residents' behaviors for an antipsychotic medication. The DON stated it is important to have an accurate record of a resident's target behaviors so that a resident receives the appropriate dosage of the antipsychotic. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy and procedure titled, Use of Psychotropic Medication (medications capable of affecting the mind, emotions, and behavior), last reviewed 1/10/2024, indicated residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition, as diagnosed and documented in the clinical record, and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication. The policy and procedure indicated the indications for initiating psychotropic medications will be determined by assessing the resident's underlying condition, current signs, symptoms, expressions, and preferences and goals for treatment. A review of the facility's policy and procedure titled, Medication Monitoring, last reviewed 1/10/2024, indicated licensed nurses, with periodic oversight by nurse managers, shall adhere to facility policies and current standards of practice for administration and monitoring of medications. A review of the facility's policy and procedure titled, Documentation in Medical Record, last reviewed 1/10/2024, indicated licensed staff and interdisciplinary team members (IDT, a group of health care professionals with various areas of expertise who work together toward the goals of the residents' care plan) shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy. The policy and procedure indicated documentation can be completed at the time of service, but no later than the shift in which the assessment, observation, or care service occurred. The policy and procedure indicated documentation shall be accurate, relevant, and complete, containing sufficient details about the resident's care and/or responses to care.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 34659 Based on observation, interview and record review, the facility failed to ensure the control solution (a solution containing sugar that is used to checking that the glucometer [a blood glucose {blood sugar} monitoring machine] is working as intended) was labeled with an open date (when a nurse first opens the container and writes the date it is open to ensure it is removed from circulation in a timely manner) in one of three medication carts (Station 1 Medication Cart). This deficient practice had the potential to compromise the therapeutic effectiveness of the control solution and can lead to inaccurate glucometer readings. Findings: During a concurrent medication cart observation and record review with Licensed Vocational Nurse 1 (LVN 1) on 4/01/2024 at 3:55 p.m., observed the control solution for the glucometer for Station 1 Medication Cart with no open date documented. LVN 1 confirmed by stating that the control solution for the glucometer did not have an open date documented. During an interview and concurrent record review with the DON on 04/02/24 at 2:20 p.m., the Don stated that an open date should be documented on the glucometer control solution to ensure the solution is not used after 90 days . The DON stated this is important so that the glucometer can accurately assess a resident's blood sugar level. During a concurrent interview and record review with the DON on 4/2/2024 at 2:20 p.m. the facility provided document titled, Assure Dose Control Solution, revised 5/2022 was reviewed. The DON stated that according to the manufacturer's guidelines, the glucometer control solution should be used within the first 90 days of opening. The guidelines further indicated that it is recommended that one writes the open date on the control solution bottle label to serve as a reminder to dispose of the solution after 90 days.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48142 Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and food preparation practices by failing to: 1. Ensure three packs of frozen sliced ham and four packs of frozen ribs observed in the facility freezer were labeled with a received date (the date a food is first delivered to the facility). 2. Ensure newly delivered was not stored directly on the facility floor. These deficient practices had the potential to place 80 of 84 residents that receive food from the facility's kitchen, at increased risk of experiencing foodborne illness (an illness that comes from eating contaminated food or drinks). 3. Ensure leftover food brought from outside was stored in the refrigerator or discarded for one of one sampled resident (Resident 12). This deficient practice had the potential to result in foodborne illness (also called food poisoning, illness caused by eating contaminated food) for Resident 12. Findings: 1. During a concurrent observation and interview on [DATE] at 7:54 a.m., with Dietary Aid 1 (DA 1), observed the following inside the kitchen freezer: a) Three packs of frozen sliced ham in a sealed package not labeled with a received date and used by date (the last day before a particular food should no longer be utilized). b) Four pack of frozen ribs in a sealed package not labeled with a received date and used by date. DA 1 stated that the three packs of frozen slied ham and the four packs of frozen ribs should have had a received date documented on them. During an interview on [DATE] at 3:03 p.m., with the Dietary Supervisor (DS), DS stated the packs of frozen ribs and sliced ham should have had a received date on them so that kitchen staff would know when they are expired. DS stated that frozen food are only to be kept in the facility for six months from the receive date. A review of the facility's policy and procedure titled, Food Storage, dated [DATE], indicated, All food stored should be dated when it was placed in the storage room, refrigerator, or freezer. 2. During a concurrent observation and interview on [DATE] at 7:32 a.m., with Dietary Aid 2 (DA 2), observed outside the dry storage room, a blue plastic container placed directly on the floor with the following contents: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. Rolled dough b. Bread c. Milk d. Box of Gelatin DA 2 stated that the container filled with food should not be placed directly on the floor. DA 2 stated the contained filled with food should have been placed on top of a pallet (platform). DA 2 stated that storing food directly on the floor can lead to food contamination because the floor is dirty. During an interview on [DATE] at 10:52 a.m. with the DS, the DS stated when the facility receives food delivery, the food should be placed on a wooden pallet. The DS stated that he has instructed the food delivery vendors multiple times to not leave food directly on the floor, but that the vendors do not listen to him. During an interview on [DATE] at 11:11 a.m., with the Infection Preventionist (IP), the IP stated that when the kitchen is receiving food delivery, the food must be placed on top of a wood pallet. The IPN further stated that the food must not be touching the floor. The IP also stated that leaving the food on the floor can lead to contamination. A review of the facility's policy and procedure titled, Storage of Food and Supplies, dated [DATE], indicated, All food and food containers are to be stored six (6) feet off the floor and on clean surfaces in a manner that protects it from contamination. 38469 3. A review of Resident 12's Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included muscle weakness, type two (2) diabetes mellitus (a chronic condition that affects the way the body processes blood glucose [sugar]), and hypertension (high blood pressure [the force of the blood pushing on the blood vessel walls is too high]). A review of Resident 12's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated [DATE], indicated the resident's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was intact and dependent on staff for toileting hygiene, shower, lower body dressing and putting on/taking off footwear. During a concurrent observation and interview on [DATE] at 9:11 a.m., observed Resident 12 in her room with two plastic containers. One contained a small piece of bread, four pieces of cut-up strawberries with a melted dressing. The other contained string beans dipped in white dressing, cut-up ham, potato salad, and two pieces of dinner rolls, with a plastic spoon and fork inside the container. The containers had no date and were not labeled. When asked about the two containers of food, Resident 12 stated that she do not know when and who brought these foods. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on [DATE] at 9:59 a.m., with Registered Nurse Supervisor 1 (RNS 1), observed the contents of Resident 12's two plastic food containers. RNS 1 stated that left over food should be labeled with the date the food was brought in by family or visitors and any leftovers are placed in the refrigerator. RNS 1 stated that within 24 hours if the food is not consumed, the leftover food is discarded. RNS 1 stated Resident 12's leftover food in the two containers are no longer safe to be at the resident's bedside because if it is consumed, it might cause the resident to get foodborne illness. A review of the facility's policy and procedure titled, Use and Storage of Food Brought in by Family or Visitors, last reviewed on [DATE], indicated, It is the right of the resident of this facility to have food brought in by family or other visitors, however, the food must be handled in a way to ensure the safety of the resident . all food items that are already prepared by the family or visitor brought in must be approved per Nursing to ensure is in accordance with the Diet Order and labeled with content and dated .

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49252 Based on interview and record review, the facility failed to maintain accurate and complete clinical records in accordance with accepted professional standards and practices for two of two sampled resident's (Resident 48 and Resident 71) Physician Documentation of Informed Consents (PDIC - informed consent) by failing to: 1. Ensure Resident 48's PDIC for Wellbutrin (medication used to treat depression) 100 milligrams (mg, a unit of measurement) was signed and dated. 2. Ensure Resident 71's PDIC for Depakote (mood stabilizer medication) 125 mg was dated by the physician who obtained the informed consent. This failure had the potential to result in confusion in the care and services for Resident 48 and Resident 71 and placed the residents at risk of receiving unwanted treatment and/or not receiving appropriate care based on their wishes due to incomplete resident medical care information. Findings: a. A review of Resident 48's Admission Record indicated the facility readmitted the resident on 3/4/2024 with diagnoses that included metabolic encephalopathy (problem in the brain caused by a chemical imbalance in the blood), dementia (decline in memory or other thinking skills severe enough to reduce a person's ability to perform everyday activities), and depression (a mood disorder that may cause persistent sadness or loss of interest in activities). A review of Resident 48's History and Physical (H&P - a formal assessment of a patient and their problem) dated 12/1/2023, indicated Resident 48 had the capacity to understand and make decisions. A review of Resident 48's Minimum Data Set (MDS, a standardized resident assessment and care screening tool) dated 3/8/2024, indicated Resident 48 had severely impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). A review of Resident 48's physician's order dated 12/8/2023, indicated an order for Wellbutrin (medication used to treat depression) oral tablet extended release 100 milligrams (mg, a unit of measurement) once daily for depression manifested by verbalization of sadness or self-striking. During a concurrent interview and record review on 4/4/2024 at 11:25 a.m., with Licensed Vocational Nurse 4 (LVN 4), reviewed Resident 48's Physician Documentation for Informed Consent, undated, for Wellbutrin 100 mg by mouth daily for depression. Resident 48's PDIC for Wellbutrin indicated, it was undated and unsigned by the physician who obtained the informed consent. LVN 4 stated the informed consent was missing the physician's signature and date. LVN 4 further stated the resident was started on Wellbutrin in 12/2023 and would have expected it to be signed by this time. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 4/4/2024 at 1:37 p.m., with the Director of Nursing (DON), reviewed Resident 48's PDIC for Wellbutrin, undated. The DON stated Resident 48's PDIC for Wellbutrin was undated and unsigned by the physician who obtained the informed consent. The DON stated informed consents were required for psychotropic drugs (medications that affect a person's mental state) and the physician needs to sign the consents. b. A review of Resident 71's Admission Record indicated the facility readmitted the resident on 2/6/2024 with diagnoses that included metabolic encephalopathy, dementia, and psychosis (a severe mental condition in which thought and emotions are so affected that contact is lost with external reality). A review of Resident 71's H&P dated 12/1/2023, indicated the resident did not have the capacity to understand and make decisions. A review of Resident 71's MDS dated [DATE], indicated Resident 71 had severely impaired cognition. A review of Resident 71's physician's orders, dated 12/20/2023, indicated an order for Depakote oral tablet delayed release 125 milligrams (mg, a unit of measurement), give one tablet by mouth one time a day and give two tablets (250 mg) by mouth in the afternoon, and give two tablets (250 mg) at bedtime for mood disorder manifested by anger outbursts. During a concurrent interview and record review on 4/4/2024 at 11:09 a.m., with Licensed Vocational Nurse 4 (LVN 4), reviewed Resident 71's Physician Documentation for Informed Consent, undated, for Depakote. Resident 71's PDIC for Depakote indicated, the consent on file did not have the signature of the physician who obtained the informed consent and was undated. LVN 4 stated Resident 71's PDIC was incomplete because it was missing the physician's signature and date. A review of Resident 71's physician's order dated 2/27/2024, indicated an order for Risperdal (risperidone - generic version; a medication used to treat mental/mood disorders) one (1) mg by mouth every 12 hours for psychosis manifested by auditory hallucinations (happen when you hear voices or noises that don't exist in reality). During a concurrent interview and record review on 4/4/2024 at 11:09 a.m., with LVN 4, reviewed Resident 71's Physician Documentation for Informed Consent, for risperidone, undated. Resident 71's PDIC for risperidone indicated the consent on file did not have a date when the physician signed and obtained consent. LVN 4 stated Resident 71's PDIC for risperidone was undated, the form was incomplete, and they would not know when the informed consent was completed. During a concurrent interview and record review on 4/4/2024 at 1:37 p.m., with the DON, reviewed Resident 71's PDIC for Depakote and risperidone, both undated. The DON stated Resident 71's PDIC for Depakote was unsigned and undated by the physician who obtained the informed consent and Resident 71's PDIC for risperidone was undated. The DON stated informed consents were required for psychotropic drugs and the physician needs to sign the consents. A review of the facility's policy and procedure titled, Documentation in Medical Record, dated 12/19/2022, indicated documentation shall be complete, documentation shall be timely, each entry should be signed with the name and credentials of the person making the entry, and a date should be recorded for every entry.

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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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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 38469 Based on observation, interview, and record review, the facility failed to: 1. Ensure a resident's nasal cannula (device used to deliver supplemental oxygen placed directly on a resident's nostrils) oxygen tubing was not touching the floor for one of two sampled residents (Resident 82) investigated for infection control. This deficient practice had the potential to result in contamination of the resident's care equipment and risk of transmission of bacteria that can lead to infection. 2. Based on observation, interview, and record review, the facility failed to maintain infection control practices by failing to ensure one of one sampled resident's (Resident 138) nasal cannula was labeled and dated. This deficient practice had the potential to cause contamination of the oxygen tubing. Findings: 1. A review of Resident 82's Face Sheet (admission record) indicated the facility originally admitted the resident on 2/6/2024 and readmitted the resident on 3/18/2024, with diagnoses including dementia (decline in memory or other thinking skills severe enough to reduce a person's ability to perform everyday activities), gastro-esophageal reflux disease (stomach contents flow backward, up into the esophagus, the tube that carries food from your throat into stomach) and chronic obstructive pulmonary disease (COPD - a chronic lung disease that makes it difficult to breathe). A review of Resident 82's History and Physical (H&P - a formal assessment of a patient and their problem) dated 3/21/2024 indicated that the resident has the capacity to understand and make decisions. A review of Resident 82's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 2/13/2024, indicated that the resident's cognitive (thought processes) skills for daily decision making was intact and the resident required maximal assistance with eating, oral hygiene, upper body dressing and personal hygiene. A review of Resident 82's physician's orders dated 3/18/2024 included an order to administer oxygen at two (2) liters per minute (L/min, a unit of measure) via nasal cannula and may titrate (gradually adjust) oxygen to maintain oxygen saturation (the amount of oxygen that's circulating in the blood) greater or equal to 92% as needed for shortness of breath. During a concurrent observation and interview on 4/1/2024 at 10:25 a.m., with the Infection Preventionist (IP), observed Resident 82's nasal cannula tubing on the floor. The IP stated that oxygen tubing should not be touching the floor because the floor is dirty and can contaminate the nasal cannula tubing which could lead to a resident acquiring an infection. The IP stated that she was going to replace Resident 82's nasal cannula tubing as it is already contaminated. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Centers for Disease Control and Prevention (CDC, national public health agency) source material, Guidelines for Environmental Infection Control in Health-Care Facilities, updated 7/2019, indicated floors can become rapidly contaminated from airborne microorganisms and those transferred from shoes, equipment wheels, and body substances. 34659 2. A review of Resident 138's Face Sheet (admission record) indicated the facility admitted the resident on 2/10/2024 and readmitted the resident on 3/20/2024 with diagnoses that included acute (sudden) and chronic respiratory failure (a long-term condition in which the respiratory system is unable to adequately exchange oxygen to the body). A review of Resident 138's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 2/14/2024, indicated Resident 138 was severely impaired in cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) with skills required for daily decision making. The MDS indicated Resident 138 was dependent on staff (helper does all of the effort) with toileting and dressing. A review of Resident 138's physician's orders indicated an order for oxygen at two liters per minute (L/min, a unit of measure) via nasal canula, may titrate oxygen to maintain oxygen saturation (SpO2, the measurement of oxygen in one's blood, normal reference range is greater than 94%) as needed for shortness of breath, dated 2/12/2024. During an observation on 4/1/2024 at 8:24 a.m., observed Resident 138 in his bed wearing a nasal canula and not labeled with a date or time. During a concurrent observation and interview on 4/1/2024 at 8:25 a.m., with Licensed Vocational Nurse 5 (LVN 5), observed Resident 138's nasal canula not labeled with a date when applied. LVN 5 stated they should have labeled the nasal canula when it was first placed to ensure it would not be there for longer than was allowed. LVN 5 stated this was important for infection control reasons. During an interview on 4/3/2024 at 10:39 a.m., with the Director of Nursing (DON), the DON stated nasal canula tubing should be changed weekly. The DON stated the date should be placed on the nasal canula tubing. The DON stated this was important to ensure the nasal canula tubing is clean and changed timely so that infection control can be maintained. A review of the facility's policy and procedure titled, Oxygen Administration, reviewed 1/10/2024, indicated one of the infection control measures for oxygen therapy is to change oxygen tubing and mask/cannula weekly.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. 38469 Based on observation, interview, and record review, the facility failed to ensure space requirements of 80 square feet for each resident were met in multiple resident bedrooms which had the potential to result in inadequate space to provide safe nursing care and privacy in 36 of 39 rooms (1, 2, 3, 4, 5, 6, 7, 8, 10, 12, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40). The room size for these rooms had the potential to have inadequate space for resident care and mobility. Findings: During a concurrent interview and record review on 4/4/2024 at 10:00 a.m., with the Administrator (Adm) reviewed the facility's room waiver request. The Adm stated the facility had a room waiver for the rooms that did not meet the required 80 square feet per resident. A review of the document titled, Client Accommodations Analysis dated 4/4/2024, submitted by the facility indicated the following rooms with their corresponding measurements: Room # No. # of beds Total Square feet/total square feet per resident 1 2 147.53/73.76 2 2 147.53/73.76 3 2 147.53/73.76 4 2 147.53/73.76 5 2 147.53/73.76 6 2 147.53/73.76 7 2 156.41/78.20 8 2 147.53/73.76 10 2 147.5/73.75 12 2 147.5/73.75 14 2 157.71/78.85 15 2 157.71/78.85 (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	16 2 157.71/78.85 17 2 157.71/78.85 18 3 215.54/71.85 19 3 212.74/70.9 20 3 212.74/70.9 21 3 212.74/70.9 22 3 211.2/70.4 23 3 211.2/70.4 24 3 211.2/70.4 26 2 150.7/72.6 27 2 150.7/75.4 28 2 150.7/75.4 29 2 150.7/75.4 30 2 150.7/75.4 31 2 150.7/75.4 32 3 213.72/71.24 33 3 213.72/71.24 34 3 213.72/71.24 35 3 213.72/71.24 36 3 213.72/71.24 37 3 213.72/71.24 38 3 213.72/71.24 39 3 213.72/71.24 40 3 213.72/71.24 (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	The square footage requirements for a two-bed capacity room is at least 160 square feet and for a three-bed capacity room is at least 240 square feet. During observations of the facility from 4/1/2024 to 4/4/2024, the above-mentioned rooms were not occupied by more than three residents; provided enough space for care, dignity, and privacy; ample room space for residents to move freely; and no concerns observed related to space or to the safe provisions of care to the residents residing in the rooms. A review of the facility-provided letter dated 4/4/2024, indicated a request for a room waiver for the above-mentioned room indicating, Each room listed on the attached 'Client Accommodations Analysis' has no projections or other obstruction, which may interfere with free movement of wheelchairs and/or sitting devices. There is enough space to provide for each resident's care, dignity, and privacy and that the rooms are in accordance with the special needs of the residents and would not have any adverse effect on the residents' health and safety or impede the ability of any resident in the rooms to attain his or her highest practicable well-being. All measures will be taken to assure the comfort of each resident. The granting of this Variance will not adversely affect the residents' health and safety and will be in accordance with any special needs of each resident.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. 48678 Based on observation, interview, and record review, the facility failed to fix one of one sampled resident's (Resident 28) call light (device used by residents that when pressed informs facility staff that assistance is being requested) after being told by Resident 28 that his light was not functioning. This deficient practice had the potential to cause a delay in resident care and for the residents' needs to remain unmet. Findings: A review of Resident 28's Admission Record indicated the facility admitted the resident on 1/29/2024 with diagnosis of diabetes mellitus (DM, a chronic condition that affects the way the body processes blood glucose [sugar]). A review of Resident 28's History & Physical (H&P - a formal assessment of a patient and their problem), dated 1/31/2024, indicated Resident 28 had the capacity to understand and make decisions. A review of Resident 28's Minimum Data Set (MDS, a comprehensive standardized assessment and screening tool) dated 1/15/2024, indicated Resident 28 had intact cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). The MDS indicated Resident 28 was dependent (helper does all of the effort) on staff for toileting and maximal assistance (helper does more than half the effort to lift or hold trunk or limbs and provides more than half the effort) from staff to shower, for lower body dressing, and putting and taking off footwear. The MDS also indicated Resident 28 required partial/moderate assistance (helper does less than half the effort to lift, hold, or support trunk or limbs, but provides less than half the effort) for mobility including toilet transfer from staff. During a concurrent observation and interview on 4/1/2024 at 9:26 a.m., with Resident 28 in Resident 28's room, Resident 28 pressed the call light and stated he had notified the staff that his light had not been working for about a week, but they have not done anything to fix it. Resident 28 stated he noticed every time he pressed the light, it would take a very long time for the staff to come to his room, and he would even fall asleep waiting for them to come in. Resident 28 stated he reported this issue to the certified nursing assistants (CNAs) and the CNAs told him that they would keep an eye out for when his room number lights up at the nurse's station so that they can come to his room when he calls, since the light bulb right outside his door was not lighting up. Resident 28 stated he was told by the staff that the light bulb outside his door was broken. During a concurrent observation and interview on 4/1/2024 at 9:34 a.m., with Registered Nurse Supervisor 1 (RNS 1) at the nurse's station, observed Resident 28's room number lit up at the nurse's station after Resident 28 had activated the call light from his room. RNS 1 stated she was aware that Resident 28's call light not working, and she would notify maintenance about the issue. RNS 1 stated the CNAs and staff monitor the lights to make sure someone responds to the call light. RNS 1 stated the consequences for resident's call light not working properly are the staff will not attend to the resident's needs which could result in resident harm such as residents having a fall. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 4/1/2024 at 9:48 a.m., with Maintenance Personnel, outside Resident 28's room, Maintenance Personnel stated he had fixed the broken light bulb after being notified by RNS 1. During an interview on 4/2/2024 at 8:30 a.m., with CNA 1 stated it was important to report a non-working call light immediately to Maintenance Personnel, or the charge nurse to prevent any bad outcomes for residents and ensure residents get assistance with their needs. A review of the facility's policy and procedure titled, Call lights: Accessibility and Timely Response, dated 12/19/2022, indicated, staff will report problems with a call light or the call system to the supervisor and/or maintenance director, and staff members who see or hear an activated call light are responsible for responding to the call light in a timely manner.