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	03/28/2025

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 0550 Level of Harm - Immediate jeopardy to resident health or safety 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** 49947 Based on observation, interview, and record review, the facility failed to protect, promote, and honor one of three sampled residents (Resident 23) right of not receiving cardiopulmonary resuscitation (CPR - emergency measures including manual chest compressions and rescue breaths to revive a person when breathing or heartbeat has stopped) measures as indicated in the Physician Orders for Life-Sustaining Treatment (POLST - a form that contains written medical orders for end-of life decisions communicated by a resident able to make informed decisions and if unable, by the resident's representative), dated [DATE]. Resident 23's POLST indicated Do Not Resuscitate (DNR- a medical order written by a doctor to instruct health care providers not to do CPR) instructing staff not to do CPR. The facility failed to ensure: 1. Registered Nurse 1 (RN 1) and Licensed Vocational Nurse 1 (LVN 1) verified Resident 23's code status (a person's wishes regarding CPR and other life-sustaining treatments in the event of cardiac arrest ([heartbeats stop] or respiratory arrest [breathing stops]) in Resident 23's POLST and Admission Record face sheet), on [DATE] at 2:04 pm, when Resident 23 was not breathing. RN 1 and LVN 1 started CPR on Resident 23 based solely on an unidentified person shouting that Resident 23 was a full code (all possible life-saving measures including CPR are attempted). 2. RN 2 and Registered Nurse Consultant 1 (RNC 1) verified Resident 23's POLST before assisting RN 1 and LVN 1 with performing CPR on Resident 23 on [DATE] from 2:04 pm to 2:11 pm (seven minutes) until paramedics (healthcare professional trained to give emergency medical care to people who are injured or ill, typically in a setting outside of a hospital) arrived and after paramedics reviewed Resident 23's POLST and Admission Record and informed the staff that were present in Resident 23's room that Resident 23 had a DNR order. 3. RN 1, RN 2, RNC 1, and LVN 1 followed the facility's P&P on Communication of Code Status which indicated the resident had the right to request, refuse and/or discontinue medical or surgical treatment and the facility is to adhere to the resident's rights. 4. RN 1, RN 2, RNC 1, and LVN 1 followed the facility's P&P on POLST that indicated the facility will honor a resident's POLST. (continued on next page)

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

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

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	03/28/2025

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 0550 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The failure to verify Resident 23's code status in the POLST and performing CPR for seven minutes violated Resident 23's wish of DNR. Not affording Resident 23's right to exercise his rights could cause distress to Resident 23 and his family had the CPR been effective. Resident 23 may have experienced unnecessary pain and suffering including broken ribs, unnecessary pain, and brain injury from lack of oxygen from receiving CPR. On [DATE] at 6:22 p.m., while onsite at the facility, the State Survey Agency (SSA) identified and called an Immediate Jeopardy (IJ, a situation in which the facility's non-compliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) situation under 42CFR S483.10 (a) Residents Rights & (b) Exercise of Rights in the presence Administrator (ADM) and the Director of Nursing (DON) due to the facility's failure to honor Resident 23's POLST after finding Resident 23 not breathing. On [DATE] at 7:53 am, the ADM submitted an acceptable IJ Removal Plan (a detailed plan to address and correct the IJ findings). While onsite at the facility, the SSA verified the IJ situation was no longer present and confirmed the facility's implementation of the IJ Removal Plan through observations, interviews, and record reviews. The SSA removed the IJ Situation in the presence of the ADM and the DON on [DATE] at 12:31 pm. The acceptable IJ Removal Plan included the following summarized actions: 1. On [DATE], the Social Services Director (SSD), the DON, and the Assistant DON (ADON) conducted an in-house audit of each resident's POLST, Advance Directive, and History & Physical (H&P) exam to determine if the resident had the capacity to make decisions and to verify the resident's responsible party (if the resident did not have the capacity to make decisions). There was a total of 82 residents residing at the facility on [DATE]. There were 21 residents with confirmed DNR status and 61 residents with confirmed Full Code status. 2. On [DATE], the Interdisciplinary Team (IDT - a group of health care professionals with various areas of expertise who work together toward the goals of the resident) reviewed the medical record of all 82 residents and verified that 61 residents were Full Code, and 21 Residents were DNR. There were 11 residents with advanced directives. 3. On [DATE] and [DATE], RNC 2 provided reinforcement training to LVN 1, RN 1, RN 2, and RNC 1 on Resident Rights, POLST, Communication of Code Status, CPR, DNR), Advance Directive, and Medical Emergency Response. 4. On [DATE], the SSD and the DON met with residents who had the capacity to make their own decisions and verified that their POLST was current. 5. On [DATE], the SSD and the DON spoke with the resident representative of each resident who did not have the capacity to make decisions, to verify if their POLST is current. All the resident representatives stated that the POLST is current and there are no changes. 6. On [DATE], the Medical Records Director (MRD) printed current Admission Record (face sheets) of each resident reflecting the verified POLST. (continued on next page)

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	03/28/2025

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 0550 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	7. On [DATE], the ADON printed out the list of all residents with their Code Status Orders Report (based on the POLST) and visibly posted the list at each nurses' stations, emergency cart, and in a binder at the medication carts. The Code Status Order Report will be updated daily by the 11pm to 7am licensed nurses and checked for accuracy. The 7am to 3pm licensed nurses will update any report not completed during the prior 11pm to 7am shift. 8. On [DATE], the DON placed DNR stickers on the outside of the 21 confirmed DNR residents' medical records to clearly display their DNR status. The 11pm to 7am licensed nurses were tasked to reconcile the Code Status Order Report daily with the DNR stickers and update as necessary. The MRD will audit the DNR stickers on the medical records and reconcile it with the Code Status Order Report weekly to ensure accuracy. The audit will be documented utilizing a Code Status audit form. Any inaccurate findings will be immediately corrected by MRD. The Code Status audit form will be available in the facility's binder with all documents related to the IJ Situation (IJ Binder). 9. On [DATE] and thereafter, the licensed nurse assigned to the desk work will discuss resident code status during huddle (a short meeting for the arriving staff prior to the start of their shift) for all three shifts (7am-3pm, 3pm-11pm, and 11pm-7am). During the huddle the nursing supervisor will assign a licensed nurse as the Shift Code Leader (a licensed nurse in charge of resident emergencies in the facility) should any incident occur. 10. On [DATE], the SSD placed red wristbands (to visually identify DNR status) on the wrists of 19 residents with DNR orders with their consent. Two residents with DNR status agreed to wear the red wristbands on [DATE]. On [DATE], all 21 with DNR orders agreed to wear the red wristbands. By [DATE], the IDT updated the Care Plans of the 21 residents with DNR orders. All licensed nurses are tasked to print the code status report and visually verify that red wristbands are worn by the residents with orders for DNR and document it on the DNR Form list. The MRD will audit residents' care plans weekly utilizing the Code Status audit form to ensure compliance and accuracy. 11. On [DATE], the ADM updated the Person-Centered Interview and Rounding Worksheet to reflect the wristband section for department managers to visually verify that the wristband is intact on their assigned residents on Monday through Friday basis. Registered Nurse (RN) supervisor will conduct the audit on weekends utilizing Weekend Room Round form. Department Managers and RN supervisor will utilize the Code Status Order Report to ensure accuracy during rounds. The Person-Centered Interview and Rounding Worksheet and Weekend Room Round forms will be available the Room Rounds binder. 12. Starting on [DATE], a mandatory facility-wide in-service training was conducted to reinforce the facility's P&P including Resident Rights, POLST, Communication of Code Status, CPR, DNR, Advance Directive, and Medical Emergency Response. By [DATE], 100% of the staff received the in-service training. New hires will be educated prior to the start of their first scheduled shift. 13. Starting on [DATE], the ADM or the DON will interview employees from different shifts on weekly basis to validate understanding of the in-service training on Resident Rights, POLST, Communication of Code Status, CPR, DNR, Advance Directive, and Medical Emergency Response. Employee response will be recorded utilizing an Employee Validation form. The form will be available in the IJ Binder. (continued on next page)

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	03/28/2025

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 0550 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	14. Starting on [DATE], regular audits during IDT meetings will include verification of the residents' clinical record for the current code status. Newly admitted residents' code status will be reviewed during IDT meetings. The audit will be done upon admission and readmission of residents, weekly for current residents or when where there is a change in residents' code status. The audits will be documented utilizing the Code Status audit form and will be reported by the MRD during Monday through Friday operations meeting for appropriate follow up. 15. On [DATE], the IDT conducted Root Cause Analysis (RCA) and identified the following: a. Code status was not immediately visible during an emergency requiring life-saving measures if appropriate. b. There was a lack of visual cues such as DNR sticker or resident identifier such as red wristbands. 16. On [DATE] a QAPI (Quality Assurance & Performance Improvement) was implemented to track and report on above audit findings. The findings will be presented at the monthly QA) Committee meeting for a minimum of three months for review and recommendations. After the initial three months, the QA Committee will decide regarding the continued frequency of audits and subsequent reporting, with audits continuing at least monthly to sustain compliance. During a review of Resident 23's Minimum Data Set (MDS - a standardized assessment and care-screening tool), dated [DATE], the MDS indicated Resident 23 had intact cognition (thought processes). The MDS also indicated Resident 23 required assistance with eating and dressing and was dependent on staff for bathing and toileting. During a review of Resident 23's POLST, dated [DATE], signed by Medical Doctor 1 (MD 1) and Resident 23, the POLST indicated DNR and to allow natural death. During a review of Resident 23's Advance Directive (a legal document that allows you to express your wishes regarding medical care in the event you become unable to make those decisions for yourself, such as due to illness or injury) Acknowledgement form, signed dated by Resident 23 on [DATE], the Advance Directive indicated Resident 23 had completed a POLST form on [DATE]. During a review of Resident 23's Advanced Directive Status Care Plan (CP) initiated on [DATE], the CP indicated a code status of DNR. The CP included interventions to follow the POLST. During a review of Resident 23's Physician's Orders, a physician order dated [DATE], indicated MD 1 ordered DNR. During a concurrent observation and interview with Resident 23 on [DATE] at 9:42 am in Resident 23's room, Resident 23 was sitting up in bed and watching television. Resident 23 stated he lived at an assisted living facility (ALF) before he got sick and was admitted to a hospital where doctors found cancer in his abdomen. Resident 23 stated he was admitted to the facility because he was too sick to return to the ALF. Resident 23 stated he chose DNR because of his cancer diagnosis. (continued on next page)

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	03/28/2025

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 0550 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an observation on [DATE] at 2:06 pm in the hallway, outside of Resident 23's room, the door was open, the privacy curtain drawn and the counting of 1,2,3, 30 repeatedly could be heard coming from Resident 23's room. A crash cart was positioned outside Resident 23's room. At 2:11 pm paramedics arrived at Resident 23's room, Paramedic 1 (PM 1) went into the room immediately. A staff member met PM 2 outside Resident 23's room and handed PM 2 a packet of documents (copies from Resident 23's medical record). PM 2 reviewed the documents and asked out loud why was the facility staff was performing CPR against Resident 23's DNR wishes. PM 2 pointed at the Admission Record and the POLST and stated that DNR was written on both forms. Four staff members were in the room assisting with performing CPR on Resident 23, LVN 1, RN 1, RN 2 and RNC 1. During an interview with LVN 2 on [DATE] at 2:16 pm, LVN 2 stated he called code blue (term that signals a medical emergency) over the intercom and called 911 at the direction of his supervisor, RN 1. LVN 2 stated he did not check for Resident 23's code status because he heard a female voice (unidentified) yell out full code. LVN 2 stated he should have checked Resident 23's chart to ensure they had the right code status to respect Resident 23's wishes. During a concurrent interview and record review with LVN 3 on [DATE] at 2:18 pm, Resident 23's POLST and Admission Record were reviewed. LVN 3 stated Resident 23's POLST and Admission Record indicated Resident 23 had a DNR order. LVN 3 stated the DNR order could also be found in the electronic medical record and staff must check and verified the resident's POLST before starting CPR to ensure the resident's end-of-life decisions are followed. LVN 3 stated he was assigned to nurse station 1 but ran over to help at nurse station 2 when he heard the overhead page Code Blue. LVN 3 stated his role during the time CPR was being performed on Resident 23 was filling out a transfer form in case Resident 23 needed hospitalization . LVN 3 stated he did not check Resident 23's POLST because he heard a female voice calling out full code and assumed Resident 23 had a full code status. During a phone interview with Physical Therapy Assistant (PTA) on [DATE] at 9:35 am, the PTA stated she entered Resident 23's room to provide physical therapy at about 2:00 pm on [DATE] and stated Resident 23 did not respond to questions when Resident 23 was normally very able to respond. PTA stated moments later the Certified Occupational Therapist Assistant (COTA) arrived and retrieved the vital signs machine. The PTA stated at that point they checked Resident 23's oxygen saturation level (amount of oxygen in the blood in percentage, normal reading is 95% to 100%) and the reading was 32% (indicating medical emergency). PTA stated that while the COTA stayed with Resident 23, she went to the nurses' station to get LVN 1. (continued on next page)

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	03/28/2025

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 0550 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with LVN 1 on [DATE] at 2:23 pm, LVN 1 stated she was the Charge Nurse at Nurses' Station 2 and PTA called her over to Resident 23's room at 2:03 pm. LVN 1 stated she quickly assessed Resident 23 and determined Resident 23 was not breathing, LVN 1 left the room to grab the crash cart as RN 1 entered the room. LVN 1 stated RN 1 yell out near the doorway to the hallway for Resident 23's code status and heard a female voice (unidentified) yelled back the resident was full code. LVN 1 stated RN 1 began chest compressions (use of hands to push down hard and fast in a specific way on the person's chest to keep blood flowing to vital organs until a regular heartbeat returns) while she (LVN 1) began rescue breaths (to provide oxygenation of the blood) Resident 23 with a bag-valve-mask (BVM - a handheld device used to manually ventilate to a person who is not breathing or having difficulty breathing). LVN 1 stated RN 1 switched compressions off with RNC 1 and RN 2. LVN 1 stated the staff members who assisted with CPR was herself, RN 1, RN 2 and RCN 1 and they did not stop CPR until paramedics arrived. LVN 1 stated PM 2 read Resident 23's Admission Record and POLST and asked why CPR was done on a person that is a DNR. LVN 1 stated she did not check Resident 23's code status but relied on the voice (unidentified) that yelled out full code. LVN 1 stated the staff did not respect Resident 23's right to be DNR and chest compressions could result in broken ribs. During a concurrent interview and record review with RN 1 on [DATE] at 2:29 pm, reviewed Resident 23's medical record including POLST and Admission Record. RN 1 stated Resident 23's code status was DNR, and it could be found on his POLST, Admission Record and in the electronic health record (EHR). RN 1 stated when he went to Resident 23's room and he determined Resident 23 was unresponsive, he yelled out in the hallway for code status and heard a female voice (unidentified) yell back two times full code. RN 1 stated although he was already in Resident 23's room, he should have confirmed who yelled out full code or asked someone to bring the chart into the room so he could verify Resident 23's code status. RN 1 stated it was wrong to go against Resident 23's wishes to die naturally and if he was resuscitated, he could have suffered more pain from broken ribs or a punctured lung. During an interview with RN 2 on [DATE] at 2:36 pm, RN 2 stated she was the supervisor of nurse station 1 and ran over to station 2 to help when she heard the code blue page. RN 2 stated while at nurse station 2, she saw Resident 23's chart open on the desk and made copies of the Admission Record and order summary report (list of current doctor's orders) to give to the paramedics when they arrived. RN 2 stated she never took the time to check for Resident 23's code status because she heard a voice yell out full code. RN 2 stated she should have checked the Admission Record at that point to confirm Resident 23' code status. RN 2 stated she then went into Resident 23's room to help and switch off compressions with RN 1 and RNC 1. During a concurrent interview and record review, on [DATE] at 3:45 pm, the facility's P&P on CPR, revised on [DATE] and Resident 23's POLST, dated [DATE] were reviewed with RNC 1. RNC 1 stated Resident 23 had a DNR code status. RNC 1 stated CPR should have stopped immediately after a staff member confirmed Resident 23 had a DNR, but the facility failed to check and confirm the resident's code status. RNC 1 stated she went into Resident 23's room during the emergency and assisted with giving chest compressions to Resident 23. RNC 1 stated she heard a female voice (unidentified) yell out from the hallway, full code when RN 1 asked for Resident 23's code status. RNC 1 stated because of the facility's actions, Resident 23 did not have a peaceful death, very frail and could have suffered broken bones or other complications had Resident 23 been successfully revived. (continued on next page)

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	03/28/2025

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 0550 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a concurrent interview and record review, on [DATE] at 4:05 pm, Resident 23's POLST dated [DATE] and the facility's P&P on Communication of Code Status, revised on [DATE], were reviewed with the DON. The DON stated Resident 23's code status was DNR. The DON stated Resident 23's wishes were not fulfilled because CPR went on for seven minutes until paramedics arrived and determined the resident's code status. The DON stated the staff should have followed the P&P which indicated the resident had the right to request, refuse and/or discontinue medical treatment. The DON stated Resident 23 had a signed POLST indicating DNR in the medical record and staff did not check and verify Resident 23's code status. The DON stated Resident 23 could have suffered broken ribs, a punctured lung or injury to his brain from the lack of oxygen. During a telephone interview with Family Member (FM 1), on [DATE] at 5:21 pm, FM 1 stated she received a call from the ADM of Resident 23' passing on [DATE]. FM 1 stated that Resident 23 was suffering while alive from many different ailments and had wished DNR. During a concurrent interview and record review, on [DATE] at 11:08 am, the CPR Inservice training conducted on [DATE] was reviewed with the Director of Staff Development (DSD). The DSD stated the code status must be confirmed as soon as CPR is started. The DSD reviewed the CPR lesson plan and stated staff must be able to verbalize when CPR should be initiated and can identify when CPR is to be continued and/or discontinued. During a telephone interview with Medical Director Doctor (MDD), on [DATE] at 1:20 pm, the MDD stated staff must respect the residents' wishes and what happened to Resident 23 was unusual occurrence (an event that deviates from the norm, often posing a risk or threat to the health, safety or well-being of the residents) which and at least one staff member should have checked the code status immediately. The MDD stated that if Resident 23 was resuscitated and intubated, it would have been unfortunate and there would have been two different scenarios once transferred to a hospital; the resident would never be able to live without mechanical ventilation (a machine that breaths for a person that cannot breathe on their own) or living with an anoxic brain injury (when the brain goes without oxygen for a prolonged period of time), causing many complications. During a telephone interview with MD 1 on [DATE] at 1:58 pm, MD 1 stated Resident 23's code status should have been verified immediately after CPR was started. MD 1 stated staff must honor each resident's rights and choices. During a telephone interview with PM 1, on [DATE] at 10:55 am, PM 1 stated it is the facility staff's responsibility to know and respect the resident's wishes. During a review of facility's (P&P) titled, Cardiopulmonary Resuscitation (CPR), revised on [DATE], the P&P indicated, if a resident experience cardiac arrest (heartbeats stop), staff will provide basic life support, including CPR, prior to the arrival of EMS, or until DNR order is known. During a review of the facility's P&P titled, Communication of Code Status, revised on [DATE], the P&P indicated the facility will follow facility policy regarding a resident's right to request, refuse and/or discontinue medical or surgical treatment and to formulate an advanced directive. The P&P indicated when an order is written pertaining to a resident's presence or absence of an advanced directive, the directions will be reflected in the medical record, for example, Do not Resuscitate. (continued on next page)

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	03/28/2025

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 0550 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of the facility's P&P titled, Physician Orders for Life Sustaining Treatment (POLST), revised on [DATE], the P&P indicated the facility will provide the resident the option to complete or honor a POLST at the time of admission. The P&P indicated the POLST would be reviewed for completeness to confirm that the wishes for life-sustaining treatment indicated in the document remain the wishes of the resident. The P&P further indicated the complete, fully executed POLST form is a legal physician order and is immediately actionable.

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	03/28/2025

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43455 Based on observation and interview, the facility failed to ensure to provide the name of the medication and its indication (reason for the use of the medication) prior to administration of the medication, affecting one (1) of five (5) residents observed for medication administration (Resident 3). This deficient practice violated Resident 3's rights to make decisions regarding their medication regimen, withhold treatment or seek alternatives, potentially resulting in psychosocial harm. Findings: During a review of Resident 3's Admission Record (a document containing demographic and diagnostic information,) dated 3/24/2025, the record indicated Resident 3 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including diabetes (a disease characterized by high blood sugar levels,) pain, osteoporosis (a condition where the bones become fragile) and anemia (a condition characterized by a lower-than-normal number of red blood cells.) During a review of Resident 3's Minimum Data Set ([MDS] - a resident assessment tool,) dated 12/20/2024, the MDS indicated Resident 3 had moderate cognitive impairment (a condition that involves increased confusion and memory loss, as well as difficulty with language and completing tasks). During an observation on 3/24/2025 at 9:29 a.m., Licensed Vocational Nurse (LVN) 4 was observed administering docusate (a medication used for bowel [intestine] management,) cranberry (a supplement used to prevent urine infections,) bisacodyl (a medication used for bowel management,) and multivitamin with mineral tablets orally to Resident 3. Resident 3 was observed swallowing the docusate, bisacodyl and multivitamin with mineral tablets with a glass of water. LVN 4 was not observed informing Resident 3 the name of each medication and its indication during administration of the medications. During a concurrent observation, Resident 3 asked LVN 4 to cut the large pill and LVN 4 stepped out of the room with the cranberry tablet. During a concurrent interview with Resident 3, Resident 3 stated she was not aware of the medications she was administered by LVN 4 and that she would like to know. LVN 4 was observed entering Resident 3's room with the cranberry tablet cut in half. LVN 4 handed a small plastic cup containing the cut cranberry tablet to Resident 3 with a glass of water. LVN 4 was not observed informing Resident 3 the cut tablet was cranberry. The state surveyor asked Resident 3 if she would like to know what medication LVN 4 handed her, and Resident 3 stated yes. LVN 4 was observed stating to Resident 3 the medication was cranberry used to prevent urine infections. Resident 3 was observed swallowing the cranberry tablets with a glass of water. (continued on next page)

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	03/28/2025

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/24/2025 at 9:35 a.m., with LVN 4, LVN 4 stated during the medication administration on 3/24/2025 at 9:29 a.m., LVN 4 administered docusate, bisacodyl and multivitamin with mineral tablets to Resident 3 and failed to inform Resident 3 the names of the medications and their indications prior to the resident swallowing each medication. LVN 4 stated that LVN 4 usually informs the residents of each medication and the indication prior to administration but forgot to do so this time. LVN 4 stated according to facility policy LVN 4 should have informed Resident 4 the name and indication of the medications administered that morning, to give Resident 4 the right to be involved in their care and treatment and be able to make choices such as refusing a specific medication. During an interview on 3/25/2025 at 12:08 p.m., with the Director of Nursing (DON,) the DON stated that LVN 4 failed to inform the name of the medications and their indications prior to medication administration on 3/24/2025 to Resident 3. The DON stated that it was important to follow this process to ensure residents have the right to be informed about their care and make decisions about their treatments. The DON stated not providing this information during medication administrations restricts the residents from this right. During a review of Resident 3's Medication Administration Record ([MAR] - a record of mediations administered to residents), dated March 2025, the MAR indicated Resident 3 was prescribed the following medications: -cranberry tablet to be given by mouth once a day for Urinary Tract Infection ([UTI] - urine infection) prophylaxis ([PPX] - prevention) at 9 a.m. -bisacodyl four (4) tablets to be given by mouth once a day for bowel (intestine) management at 9 a.m. -docusate tablet to be given by mouth twice a day for bowel management at 9 a.m. and 5 p.m. -multivitamin with mineral tablet to be given by mouth once a day every Monday and Thursday for supplement at 9 a.m. During a review of the facility's policy and procedures (P&P), titled Resident Rights, last reviewed 1/15/2025, the P&P indicated: 2. The resident has the right to be informed of, and participate in, his or her treatment, including: e. The right to request, and/or discontinue treatment.

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	03/28/2025

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 38469 Based on interview and record review, the facility failed to keep a copy of a resident's Advance Directive (a legal document indicating resident preference on end-of-life treatment decisions) in the medical record for one (Resident 21) out of 6 sampled residents reviewed under Advance Directive. This deficient practice had the potential to create confusion, which could lead to conflict with the resident's wishes regarding his/her health care. Findings: During a review of Resident 21's Admission Record, the Admission Record indicated the facility admitted the resident on 7/23/2024 with diagnoses including dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life) and hypertension (high blood). During a review of Resident 21's Minimum Data Set (MDS - a resident assessment tool), dated 1/22/2025, the MDS indicated the resident had the ability to usually makes self- understood and the ability to usually understand others and totally dependent on staff for most activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a concurent interview and record review on 3/26/25 at 9:51 a.m., with the Minimum Data Set Coordinator (MDSC), reviewed Resident 4's Advance Directive Acknowledgement Form dated 7/24/24. The MDSC stated the form indicated that Resident 21 had executed an advance directive, and a copy was provided to the facility. The MDSC stated there is no copy of the advance directive filed in Resident 21's physical chart or electronic record. The MDSC stated that an advance directive would indicate the resident`s healthcare wishes, and it is important to have it accessible in emergencies, as it allows the facility to determine whether a resident wishes to receive full treatment or not. The MDSC stated that it is a violation of the resident`s rights if his/her healthcare wishes are not honored. During a review of the facility`s policy and procedure (PP), titled Residents` Rights Regarding Treatment and Advance Directive, last reviewed on 1/15/205, the PP indicated that Upon admission, should the resident have an advance directive, copies will be placed on the chart as well as communicated to staff .

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	03/28/2025

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 38549 Based on interview and record review, the facility failed to update a resident's care plan (a comprehensive document that outlines a patient's healthcare needs, goals, and interventions) to reflect his current nutrition status for one (Resident 2) out of two sampled residents investigated for tube feeding (a method of providing nutrition to individuals who are unable or unwilling to eat or drink adequately). This deficient practice had the potential to result in the resident receiving incorrect care from providers. Findings: During a review of Resident 2's Admission Record, the Admission Record indicated the facility originally admitted the resident on 3/1/1998 and readmitted the resident on 7/9/2024 with diagnoses including quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury) and encounter for attention to gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated 1/29/2025, the MDS indicated the resident had intact cognition (thought processes) and was dependent on staff for all activities of daily living (ADLs - activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 2's physician's orders, the orders indicated the following: 1. Nothing by mouth (NPO) diet (ordered on 7/9/2024) 2. Enteral feed (a form of nutritional support that provide nutrients directly into the gastrointestinal [GI] tract through a tube) order every shift - Formula: Fibersource High Nitrogen (HN) 1.2 kilocalories (kcal - unit of measurement) - Rate 80 cubic centimeters (cc - unit of measurement) per hour - Start at 1 p.m. time until 1600 milliliters (ml - unit of measurement) has infused to provide 1600 ml/1920 kcal (ordered on 3/23/2025). 3. Oral gratification: Ice chips (ordered on 3/24/2025). (continued on next page)

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	03/28/2025

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/28/2025 at 9:13 a.m., during a concurrent interview and record review, reviewed Resident 2's care plans with Minimum Data Set Coordinator (MDSC). The MDSC stated that, according to the resident's care plan for risk for malnutrition (a condition that occurs when a person does not receive enough nutrients or energy to meet their body's needs) due to the resident being on tube feeding, initiated on 4/29/2022, one of the interventions indicated to give the Resident 4 ounces (oz - unit of measurement) of puree (a smooth, blended consistency of food that has been processed to remove lumps and make it easier to eat) three times a day (TID) during mealtimes with one-to-one supervision for oral gratification. Reviewed physician's orders with the MDSC. The MDSC verified that the resident had an order to be NPO. The MDSC stated the care plan should have been updated to reflect the resident's NPO status. On 3/28/2025 at 10:10 a.m., during an interview, the Director of Nursing (DON) stated it was important to update residents' care plans because they reflected the care and services that should be provided to meet the residents' goals. The DON stated that, if not updated, then staff may potentially follow incorrect interventions. During a review of the facility's policy and procedure titled, Comprehensive Care Plans, last reviewed and revised on 1/15/2025, the policy and procedure indicated that the comprehensive care plan will describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment.

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	03/28/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 38469 Based on observation, interview, and record review, the facility failed to ensure the resident's Low Air Loss Mattress (LALM - a pressure-relieving mattress used to prevent and treat pressure injuries) was set according to the resident's weight for one of three sampled residents (Resident 21) reviewed under the pressure ulcer/injury (localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device) care area. This deficient practice had the potential to place Resident 21 at risk for discomfort and increase the resident's risk for the development of pressure injuries. Findings: During a review of Resident 21's Admission Record, the Admission Record indicated the facility admitted the resident on 7/23/2024 with diagnoses including dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life) and hypertension (high blood pressure). During a review of Resident 21's Minimum Data Set (MDS - a resident assessment tool), dated 1/22/2025, the MDS indicated the resident had the ability to usually makes self- understood and the ability to usually understand others and totally dependent on staff for most activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 21`s Physician`s order, dated 11/13/2024, the Physician's Order indicated an order to provide LALM for skin management. During a review of Resident 21's Care Plan (a document that outlines the actions and interventions needed to address a resident's health and care needs) initiated on 8/02/2024 and revised on 1/24/2025, the care plan indicated Resident 21 had potential for pressure ulcer development related to immobility and incontinence (involuntary loss of urine). The care plan indicated an intervention to monitor LALM for proper functioning. During an observation on 03/25/25 at 08:14 a.m., observed Resident 21 lying in bed sleeping on a LALM that was set at 174 pounds (lbs.) to 210 lbs. weight range. During an interview and record review on 3/26/2025 at 9:43 a.m., with Minimum Data Set Coordinator (MDSC) reviewed Resident 21`s current weight. The MDSC stated Resident 21's weight as of 3/05/2025 is 133 lbs. The MDSC stated that the LALM should be checked every shift for proper functioning and to ensure the setting was according to the resident`s current weight. During a follow-up observation on 3/26/2025 at 10:00 a.m., with the MDSC, in Resident 21`s room, the LALM was set at 174-210 lbs. range. The MDSC stated that the setting in not correct because the resident`s weight is 133 lbs. The MDSC stated that if the surface is too firm, it may increase the risk of skin impairment for the resident, potentially leading to pressure injury. (continued on next page)

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	03/28/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility`s policies and procedures (PP), titled Pressure Injury Prevention and Management, last reviewed on 1/15/2025, the PP indicated that This facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries . During a review of the facility`s policies and procedures (PP), titled Use of Support Surfaces, last reviewed on 1/15/2025, the PP indicated that support surfaces will be used in accordance with evidence-based practice for residents with or at risk for pressure injuries .

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	03/28/2025

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 38549 Based on interview and record review, the facility failed to ensure licensed nurses attempted nonpharmacological interventions (treatments or strategies that do not involve the use of medications) prior to administering as needed (PRN) hydrocodone-acetaminophen (medication used to treat severe pain) for one (Resident 18) out of four sampled residents reviewed for pain management. This deficient practice had the potential to place the resident at increased risk of experiencing adverse side effects such as drowsiness, constipation, and decrease in respiration. Findings: During a review of Resident 18's Admission Record, the Admission Record indicated the facility admitted the resident on 2/24/2025 with diagnoses including stage 3 pressure ulcer (full-thickness loss of skin; dead and black tissue may be visible) on the left buttock, history of falling, right hip pain, intervertebral disc degeneration (a condition where the cushioning discs between vertebrae in the spine break down or deteriorate, often due to aging or injury, leading to pain and potentially other issues), and poisoning by opioids (powerful pain-reducing medications). During a review of Resident 18's Minimum Data Set (MDS - a resident assessment tool), dated 3/5/2025, the MDS indicated the resident had intact cognition (thought processes) and required moderate assistance from staff for most activities of daily living (ADLs - activities such as bathing, dressing and toileting a person performs daily). On 3/28/2025 at 9:20 a.m., during a concurrent interview and record review, reviewed Resident 18's physician's orders with Minimum Data Set Coordinator (MDSC). MDSC verified the following: 1. The physician ordered hydrocodone-acetaminophen oral tablet 5-325 milligrams (mg - unit of measurement), give one (1) tablet by mouth every 6 hours as needed for moderate pain (5-7/10) not to exceed (NTE) 3 grams (gm - unit of measurement) per day acetaminophen (APAP) from all sources. Hold if respiratory rate (RR) is less than 12 or sedation and notify medical doctor (MD)/nurse practitioner (NP) (ordered on 3/24/2025). 2. The physician ordered hydrocodone-acetaminophen oral tablet 5-325 mg, give two (2) tablets by mouth every 6 hours as needed for severe pain (8-10/10) NTE 3 gm/day APAP from all sources. Hold if RR is less than 12 or sedation and notify MD/NP (ordered on 3/24/2025). Reviewed the resident's 3/2025 Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) with MDSC. MDSC confirmed that licensed nurses did not document any attempted nonpharmacological interventions prior to administering PRN hydrocodone-acetaminophen on the following dates and times: 1. 2/27/2025 at 8 p.m. 2. 3/4/2025 at 1:26 a.m. (continued on next page)

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	03/28/2025

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. 3/6/2025 at 2:23 p.m. 4. 3/7/2025 at 11:35 a.m. 5. 3/9/2025 at 6 p.m. 6. 3/11/2025 at 4:58 p.m. 7. 3/13/2025 at 11:41 a.m. 8. 3/15/2025 at 7:39 a.m. 9. 3/15/2025 at 2:39 p.m. 10. 3/16/2025 at 11:54 a.m. 11. 3/16/2025 at 7 p.m. 12. 3/19/2025 at 8:34 a.m. 13. 3/22/2025 at 4:53 a.m. 14. 3/25/2025 at 9:22 a.m. On 3/28/2025 at 10:07 a.m., during an interview, the Director of Nursing (DON) stated it was important to attempt nonpharmacological interventions prior to administering PRN opioids because it might be effective in treating the pain. The DON stated their goal was to not overmedicate residents because overmedication can cause lethargy, a decrease in respirations, and confusion. During a review of the facility's policy and procedure titled, Pain Management, last reviewed and revised on 1/15/2025, the policy and procedure indicated nonpharmacological interventions will include but are not limited to environmental comfort measures (e.g. adjusting room temperature, smoothing linens, comfortable seating, assistive devices or pressure redistributing mattress and positioning), loosening any constrictive bandage, clothing or device, applying splinting (e.g. pillow or folded blanket), physical modalities (e.g. cold compress, warm shower/bath, massage, turning and repositioning), exercises to address stiffness and prevent contractures as well as restorative nursing programs to maintain joint mobility, and cognitive/behavioral interventions (e.g. music, relaxation techniques, activities, diversions, spiritual and comfort support, teaching the resident coping techniques and education about pain).

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	03/28/2025

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50033 Based on interview and record review, the facility failed to ensure that one of two sampled residents (Resident 27) investigated under dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney[s] have failed) received services consistent with professional standards of practice by failing to ensure the pre-dialysis assessment was communicated to Resident 27's dialysis center on 3/7/2025. This deficient practice placed the resident at risk for developing complications such as bleeding at the dialysis access site, high or low blood pressure, and delays in care. Findings: During a review of Resident 27's Admission Record, the Admission Record indicated the facility admitted Resident 27 on 1/9/2025 and readmitted on [DATE] with diagnoses including, but not limited to, End Stage Renal Disease (ESRD-irreversible kidney failure), dependence on renal dialysis, and a left lower leg fracture. During a review of Resident 27's History and Physical (H&P) dated 1/11/2025, the H&P indicated the resident had the capacity to understand and make decisions. The H&P further indicated Resident 27 has dialysis on Mondays, Wednesdays, and Fridays. During a review of Resident 27's Minimum Data Set (MDS - a resident assessment tool), dated 1/12/2025, the MDS indicated the resident had intact cognition (the mental action or process of acquiring knowledge and understanding), and required moderate or substantial assistance for most activities of daily living (ADLs-activities such as bathing, dressing and toileting a person performs daily). The MDS further indicated Resident 27 was on dialysis. During a concurrent interview and record review on 3/28/2025 at 12:20 p.m. with the Director of Nursing (DON), Resident 27's Dialysis Communication Form, dated 3/7/2025 was reviewed. The Dialysis Communication Form did not indicate Resident 27's vital signs were taken prior to the resident going to dialysis on 3/7/2025. The DON stated it is important to assess the resident before they go to dialysis and communicate the assessment to the dialysis center because if the assessment is abnormal the resident could be harmed by going to dialysis. The DON stated Licensed Vocational Nurse 5 (LVN 5) would have been the nurse that assessed her that morning. During an interview on 3/28/2025 at 1:42 p.m. with LVN 5, LVN 5 stated she does not know why the assessment on 3/7/2025 would not have been filled out on Resident 27's Dialysis Communication Form. LVN 5 stated the Dialysis Communication Form is used to inform the dialysis center of the resident's assessment before arriving to dialysis. LVN 5 stated it is important to communicate the pre-dialysis assessment because if something were to happen while the resident is being transported to dialysis they would not know if the resident was stable before leaving the facility. (continued on next page)

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	03/28/2025

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Hemodialysis last reviewed 1/25/2025, the P&P indicated the facility will assure that each resident receives care and services for the provision of dialysis consistent with professional standards of practice including monitoring for complications before and after dialysis treatments and ongoing communication and collaboration with the dialysis facility.

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	03/28/2025

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 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** 43455 Based on interview and record review the facility failed to: 1. Include the witness signatures on the Medication Disposition Record/Pass Log for seven (7) non-CMs disposed on 2/14/2025, 13 on 2/28/2025, and eight (8) on 3/23/2025. 2. Account for one (1) dose of Controlled Substances (also known as Controlled Drug and Controlled Medications [CS, CD, CM]- medications which have a potential for abuse and may also lead to physical or psychological dependence) for Residents 21, in one (1) of two (2) inspected medication carts (Medication Cart Station 1 Cart 1.) 3. Reconcile (the process of comparing transactions and activity to supporting documentation) one (1) medication emergency kit (ekit) containing CMs for March 2025, in one (1) of tw2 (2) inspected medication carts (Medication Cart Station 1 Cart 1.) As a result, control and accountability of medications and CS's did not follow state and federal regulations and facility policy and procedures. These deficient practices increased the opportunity for CS diversion (the transfer of a controlled medication or other medication from a lawful to an unlawful channel of distribution or use,) the risk that Residents 21 and other residents in the facility could have accidental overdose (administering more than the prescribed dose causing adverse drug reactions [unwanted, uncomfortable, or dangerous effects that a medication may have, such as coma (a state of deep unconsciousness) and exposure to harmful medications, and delayed medication treatment during emergencies possibly leading to physical and psychosocial harm, and hospitalization . Findings: During an observation and record review on 3/25/2025 at 9:58 a.m. with Licensed Vocational Nurse (LVN) 1 in Medication Room Station 2, the Medication Disposition Record/Pass Logs were reviewed. The Medication Disposition Record/Pass Logs indicated: 1. Seven (7) non-CM disposals did not contain the witness signatures on the log dated 2/14/2025. 2. 13 non-CM disposals did not contain the witness signatures on the log dated 2/28/2025. 3. Eight (8) non-CM disposals did not contain the witness signatures on the log dated 3/23/2025. During a concurrent interview, LVN 1 stated LVN 1 was unable to locate the witness signatures of licenses nurses on the reviewed disposition logs. LVN 1 stated licensed nurses failed to follow policy of signing the logs with a witness when disposing medications, including herself and per facility policy a witness signature was required to ensure there was no diversion of medications. (continued on next page)

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	03/28/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 3/25/2025 at 10:22 a.m., with LVN 3, in Medication Cart Station 1 Cart 1 there was: 1. One (1) medication ekit labeled314 containing CMs without an accountability log for the reconciliation of CM inventory at every shift change for March 2025. 2. A discrepancy in the count between the Antibiotic or Controlled Drug Record accountability log and the amount of medication remaining in the medication bubble pack (medication packaging system that contains individual doses of medication per bubble) for the following resident: a. One (1) dose of pregabalin (a CS used for neuropathy [condition where nerves become damaged]) 25 milligram ([mg] - a unit of measure of mass) capsule was missing from the medication bubble pack compared to the count indicated on the Antibiotic or Controlled Drug Record accountability log for Resident 21. The Antibiotic or Controlled Drug Record accountability log for pregbalin indicated the medication bubble pack should have contained a total of 9 pregabalin 25 mg capsules, after the last administration of pregabalin 25 mg capsule documented/signed-off on 3/24/2025 at 5 p.m., however the medication bubble pack contained 8 pregabalin 25 mg capsules and contained no other documentation of subsequent administrations. During a concurrent interview, LVN 3 stated that all CMs, including medication ekits containing CMs should be reconciled at every shift. LVN 3 stated that the ekit labeled 314 containing CMs in Station 1 Cart 1 was not reconciled at every shift in March 2025, and it was important to account for all CMs to ensure accountability, prevent CM diversion and accidental exposure of harmful substances to residents. During the same interview, LVN 3 stated LVN 3 administered pregabalin 25 mg capsule to Resident 21 that morning (3/25/2025) at 9 a.m. and forgot to sign the Antibiotic or Controlled Drug Record accountability log. LVN 3 stated LVN 3 failed to follow the facility's policy of signing each CS dose on the Antibiotic or Controlled Drug Record accountability log after preparing the dose for the resident. LVN 3 stated LVN 3 understood it was important to sign each dose once administered to ensure accountability, prevent CS diversion and accidental overdose to Resident 21. During an interview on 3/25/2025 at 12:08 p.m., with the Director of Nursing (DON,) and in the presence of Registered Nurse Consultant 1 (RNC 1) the DON stated that medication ekits containing CMs needed to be counted and reconciled at every shift change to ensure accountability and prevent CM diversion. The DON stated one (1) eKit containing CMs in Station 1 Medication Cart 1 was not reconciled at each shift change for March 2025. The DON stated that the facility will immediately implement an accountability log for reconciliation of eKit at each shift change in Station 1 Medication Cart 1. During the same interview, the DON stated that LVN 3 failed to follow facility policy of documenting the preparation of CM immediately on the Antibiotic or Controlled Drug Record accountability log for Resident 21. The DON stated not documenting the Antibiotic or Controlled Drug Record accountability log timely can lead to accountability failures, CM diversion, inaccurate clinical records, and accidental use and overdose of harmful substances for residents. The DON stated she was unable to locate the witness signatures on the identified Medication Disposition Record/Pass Logs for non-CMs disposal. The DON stated licensed nurses failed to include the signatures of witnesses when destroying medications. The DON stated it was important to verify and sign these logs with witnesses to prevent medication diversions and accidental exposure to residents. (continued on next page)

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	03/28/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 21's Admission Record (a document containing demographic and diagnostic information,) dated 3/25/2025, the record indicated Resident 21 was originally admitted to the facility on [DATE] with diagnoses including polyneuropathy (condition where multiple nerves are damaged.) During a review of Resident 21's Medication Administration Record ([MAR] - a record of mediations administered to residents), for March 2025, the MAR indicated Resident 21 was prescribed pregabalin 25 mg capsules one (1) capsule by mouth twice a day for neuropathy, to be given at 9 a.m. and 5 p.m. During a review of the facility's policy and procedures (P&P), titled Destruction of unused drugs, last reviewed 1/15/2025, the P&P indicated: 5. The actual destruction of drugs by our facility must be witnessed by facility staff as per state requirements. During a review of the facility's P&P, titled Controlled Substance Administration & Accountability, last reviewed 1/15/2025, the P&P indicated The facility will have safeguards in place in order to prevent loss, diversion or accidental exposure. e. All controlled substances are accounted for in one of the following ways: i. All controlled substances obtained from non-automated medication cart or cabinet are recorded on the designated usage form. Written documentation must be clearly legible with all applicable information provided. h. The Controlled Drug Record (or other specified form) serves the dual purpose of recording both narcotic (controlled medication) disposition and patient administration. i. The Controlled Drug Record is a permanent medical record document and in conjunction with the MAR is the source for documenting any patient-specific narcotic dispensed from the pharmacy. 9. For areas without automated dispensing systems, two (2) licensed nurses account for all controlled substances and access keys at the end of each shift.

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	03/28/2025

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43455 Based on observation, interview, and record review, the facility failed to ensure that its medication error rate was less than five (5) percent (%). Three (3) medication errors out of 28 total opportunities contributed to an overall medication error rate of 10.72% affecting two (2) of five (5) residents observed for medication administration (Resident 45 and 48.) The medication errors were as follows: 1. Resident 45 did not receive a form of vitamin B complex (a supplement containing several B vitamins used in production of red blood cells) as ordered by Resident 45's physician. 2. Resident 48 received docusate (docusate (a medication used for bowel [intestine] management,) and cyanocobalamin (a medication used to treat low levels of vitamin B12), at a different time than ordered by Resident 48's physician. These failures had the potential to result in Resident 45 and 48 to experience medication adverse effects (unwanted, uncomfortable, or dangerous effects that a medication may have) and the potential to result in Residents 45's and 48's health and well-being to be negatively impacted. Findings: During an observation on 3/24/2025 at 9:15 a.m., in Medication Cart Station 1 Cart 1, Licensed Vocational Nurse (LVN) 4 was observed administering vitamin B with vitamin C tablet to Resident 45. Resident 45 was observed swallowing the tablet with a glass of water. During an interview on 3/24/2025 at 11:15 a.m., with LVN 4, LVN 4 stated that LVN 4 administered a form of vitamin B complex tablet that contained vitamin C to Resident 45 during the morning medication administration at 9:15 a.m. to Resident 45. LVN 4 stated that LVN 4 failed to follow the physician order to administer vitamin B complex without vitamin C to Resident 45. LVN 4 stated that LVN 4 failed to follow 5 rights of medication administration and as a result administered the incorrect medication to Resident 45. LVN 4 stated this was considered a medication error and needed to inform the physician. During an observation on 3/24/2025 at 9:53 a.m., in Medication Cart Station 1 Cart 2, LVN 2 was observed preparing several medications for Resident 48. During an observation on 3/24/2025 at 10:10 a.m., LVN 2 was observed administering several medications to Resident 48. LVN 2 was not observed administering docusate and cyanocobalamin. (continued on next page)

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	03/28/2025

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/24/2025 at 11:10 a.m., with LVN 2, LVN 2 stated that LVN 2 administered docusate and cyanocobalamin tablets at 7:27 a.m. and documented the administration at 10:18 a.m. to Resident 48 in error. LVN 2 acknowledged the physician's order specified to administer docusate and cyanocobalamin at 9 a.m. LVN 2 stated, per facility policy, there was a 60-minute window before and after the scheduled time for medication administration and LVN 2 administered the cyanocobalamin earlier than that timeframe. LVN 2 stated that LVN 2 failed to follow 5 rights of medication administration, failed to document the correct time of administration and that these were considered medication errors. During an interview on 3/25/2025 at 12:08 p.m., with the Director of Nursing (DON,) and in the presence of Registered Nurse Consultant 1 (RNC 1) the DON stated that LVN 4 failed to administer the correct vitamin B complex to Resident 45, and LVN 2 failed to administer docusate and cyanocobalamin tablets to Resident 48 at the scheduled time, according to the physician orders. The DON stated that licensed nurses should follow facility medication administration guidelines to ensure physician orders are followed and the right medications at the right times are administered to residents. During a review of Resident 45's Admission Record (a document containing demographic and diagnostic information,) dated 3/24/2025, the record indicated Resident 45 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including anemia (a condition with low red blood cells.) During a review of Resident 45's Order Summary Report, dated 3/24/2025, indicated Resident 45 was prescribed vitamin B complex one (1) tablet once a day in the morning orally for supplement, starting 3/5/2025. During a review of Resident 45's Medication Administration Record ([MAR] - a record of mediations administered to residents), for March 2025, the MAR indicated Resident 45 was prescribed vitamin B complex to give one (1) tablet orally once a day in the morning for supplement, at 9 a.m. During a review of Resident 48's Admission Record dated 3/24/2025, the record indicated the facility originally admitted Resident 48 on 3/8/2024 and readmitted on [DATE] with diagnoses including anemia. During a review of Resident 48's Order Summary Report, dated 3/24/2025, indicated Resident 48 was prescribed: 1. cyanocobalamin 1000 microgram ([mcg] - a unit of measure of mass) tablet once a day for supplement, starting 2/25/2025. 2. docusate 100 milligram ([mg]- a unit of measure of mass) tablet twice a day for bowel management, starting 3/15/2025. During a review of Resident 48's MAR for March 2025, the MAR indicated Resident 48 was prescribed: 1. cyanocobalamin 1000 mcg tablet to give one (1) tablet once a day orally for supplement, at 9 a.m. (continued on next page)

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	03/28/2025

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. docusate 100 mg tablet to give one (1) tablet twice a day orally for bowel management, at 9 a.m. and 5 p. m. During a review of Resident 48's medication administration details, dated 3/24/2025, the documentation indicated: 1. cyanocobalamin was scheduled at 9 a.m. and LVN 2 administered cyanocobalamin 1 tablet to Resident 48 on 3/24/2025 at 10:18 a.m. 2. docusate was scheduled at 9 a.m. and LVN 2 administered docusate 1 tablet to Resident 48 on 3/24/2025 at 10:18 a.m. During a review of the facility's policy and procedures (P&P), titled Administering Medications, last reviewed 1/15/2025, the P&P indicated that Medications are administered as prescribed . Preparation 3. Prior to administration, the medication and dosage schedule on the resident's MAR is compared with the medication label. Administration 2. Medications are administered in accordance with written orders of the attending physician. 10. Medications are administered within 60 minutes of scheduled time (1 hour before and 1 hour after) . Documentation 1. The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given. During a review of the facility's P&P, titled Medication Errors, last reviewed 1/15/2025, the P&P indicated It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by ensuring residents receive care and services safely in an environment free of significant medication errors. Medication error means the observed or identified preparation or administration of medications .which is not in accordance with the prescriber's order . Medication error rate is determined by calculating the percentage of errors observed during medication administration observation. 1. The facility shall ensure medications will be administered as follows a. According to physician's orders. (continued on next page)

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	03/28/2025

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. The facility must ensure that it is free of medication error rate of 5% or greater as well as significant medication error events. 4. The facility will consider factors indicating error in medication administration, including, but not limited to, the following: a. Medication administered not in accordance with the prescriber's order. Examples include, but not limited to: i. Incorrect dose, route of administration, dosage form, time of administration ii. Medication omission iii. Incorrect medication 7. To prevent medication errors and ensure safe medication administration, nurses should verify the following information: b. Right medication, dose, route, and time of administration.

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	03/28/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43455 Based on observation, interview, and record review the facility failed to: 1. Label one open insulin (medication used to regulate blood sugar levels) Humulin N (intermediate-acting insulin) Kwikpen (a type of device containing insulin) stored at room temperature for Resident 70, in accordance with manufacturer's requirements in one (1) of two (2) inspected medication carts (Medication Cart Station 1 Cart 1.) This deficient practice increased the risk that Resident 70 could receive medication that had become ineffective or toxic due to inadequate storage, and labeling, experience medication adverse consequences (unwanted, uncomfortable, or dangerous effects that a medication may have) resulting in the negative impact to residents' health and well-being possibly leading to health complications, hospitalization , or death. Findings: During an observation on [DATE] at 10:22 a.m., in Medication Cart Station 1 Cart 1, and in the presence of Licensed Vocational Nurse (LVN) 3, the following medication was found either stored in a manner contrary to their respective manufacturer's requirements, not labeled with an open date as required by their respective manufacturer's specifications, or stored and labeled contrary to facility policies: 1. One (1) open and used insulin Humulin N Kwikpen for Resident 70 was found stored at room temperature without a date indicating when storage or use at room temperature began. Additional label indicated pharmacy prepared the medication on [DATE] and once pen was opened to discard unused medication after 14 days. According to the manufacturer's product labeling, opened and used Humulin N kwikpens should be stored at room temperature up to 86 degrees Fahrenheit and to discard pen after 14 days even if it still contains. (continued on next page)

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	03/28/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview with LVN 3, LVN 3 stated the insulin Humulin N Kwikpen for Resident 70 was open, used, stored at room temperature, and not labeled with a date when use at room temperature began. LVN 3 stated insulin pens were multi-use (used more than once) medications that had different expiration dates once opened. LVN 3 stated according to the medication label the Kwikpen needed to be discarded after 14 days of use, and after that day the insulin loses potency (the strength of medication) and considered expired. LVN 3 stated that LVN 3 was unaware when the insulin Humulin N Kwikpen for Resident 70 was opened or stored at room temperature therefore unknown when it would expire. LVN 3 stated the Kwikpen needed to be removed from the medication cart to ensure expired insulin was not administered in error to Resident 70. LVN 3 stated administering expired insulin in error will not be effective in keeping the blood sugar stable and can harm Resident 70 by causing high blood sugar levels, leading to shock and coma (a state of deep unconsciousness caused by injury or illness), hospitalization or even death. LVN 3 stated the insulin Humulin N kwikpen needed to be immediately replaced with new ones from pharmacy for 70. During an interview on [DATE] at 12:08 p.m., with the Director of Nursing (DON,) and in the presence of Registered Nurse Consultant 1 (NC ,) the DON stated the insulin Humulin N Kwikpen for Resident 70 was not labeled with a date when the pen was first opened and used. The DON stated several LVN's failed to label the date the pen was opened and used. The DON stated without knowing when the Kwikpen was opened it was unknown when the Kwikpen expired potentially leading to the administration of expired insulin to Resident 70. The DON stated expired insulins have lost potency and effectiveness and when administered in error were not effective in controlling blood sugar levels leading to hyperglycemia (high blood sugar level) and adverse effects for Resident 70, potentially resulting in hospitalization due to Diabetic Ketoacidosis ([DKA] - a condition that develops when the body doesn't have enough insulin resulting in the buildup of acid in the blood to levels that can be life threatening.) The DON stated the Humulin N Kwikpen was considered expired and needed to be replaced with a new one from pharmacy because pen had an unknown expiration date due to lack of labeling. During a review of the facility's Policy & Procedures (P&P,) titled Labeling of Medications and Biologicals, last reviewed [DATE], the P&P indicated All medications and biologicals used in the facility will be labeled in accordance with current state and federal regulations to facilitate consideration of precautions and safe administration of medications. 1. Labels for multi-use vials must include: a. The date the vial was initially opened b. All opened .vials should be discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for the opened vial. 2. Multi-dose vials that are not opened or accessed are discarded according to the manufacturer's expiration date.

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	03/28/2025

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 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** 50033 Based on interview and record review, the facility failed to ensure that one of 22 sampled residents (Resident 64) had accurately documented medical records when the resident's code status (a patient's documented wishes regarding the level of medical intervention to be provided in a medical emergency, specifically if their heart or breathing stops) indicated in Resident 64's Physician Orders for Life-Sustaining Treatment (POLST - a form that contains written medical orders for healthcare professionals regarding specific medical treatments that can or cannot be done at the end-of life), dated [DATE] and signed by the physician on [DATE] was not accurately reflected in the Admission Record and Interdisciplinary Care Conference meeting notes, dated [DATE]. This deficient practice placed the resident at risk for not having her wish to allow for a natural death honored. Findings: During a review of Resident 64's Admission Record, the Admission Record indicated the resident was admitted on [DATE] with diagnoses including, but not limited to, psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), schizophrenia (a mental illness that is characterized by disturbances in thought), and hypotension (low blood pressure). During a review of Resident 64's Minimum Data Set (MDS - a resident assessment tool), dated [DATE], the MDS indicated Resident 64 had moderately impaired cognition (thought processes) and required assistance from staff for most activities of daily living (ADLs - activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 64's History and Physical (H&P) dated [DATE], the H&P indicated the resident had the capacity to understand and make decisions. During a concurrent interview and record review on [DATE] at 4:45 p.m. with the Director of Nursing (DON) and Administrator (ADM), Resident 64's medical record was reviewed. The printed Admission Record inside Resident 64's medical records binder indicated the resident was a full code (a medical term that indicates a patient's wish to receive all possible life-saving measures in the event of a cardiac or respiratory arrest) while the POLST, dated [DATE] and signed by the physician on [DATE], indicated the resident elected to allow for a natural death and DNR (do not resuscitate- a medical order written by a doctor to instruct health care providers not to do cardiopulmonary resuscitation [CPR] if breathing stops or the heart stops beating) orders. The DON stated the Admission Record and the POLST should match. During a concurrent interview and record review on [DATE] at 9:53 a.m. with the DON, Resident 64's Interdisciplinary Care Conference meeting notes, dated [DATE], indicated Resident remains full code The DON stated the Interdisciplinary Care Conference meeting notes did not match Resident 64's POLST and she would interview the resident to clarify her wishes. (continued on next page)

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	03/28/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 1:49 p.m. with the DON, the DON stated, she confirmed with Resident 64 that she wishes to continue with the DNR status. The DON further stated it is important to have the resident's code status accurately reflected in the medical record so there is no confusion about the resident's wishes, and they can honor her rights. During a review of the facility's policy and procedure (P&P) titled, Communication of Code Status last reviewed [DATE], the P&P indicated the facility will implement procedures to communicate a resident's code status to those individuals who need to know this information including reviewing the code status as needed and documenting it in the medical record.

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	03/28/2025

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 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. 38549 Based on observation, interview, and record review, the facility failed to ensure that 36 of 38 resident rooms (Rooms 1, 2, 3, 4, 5, 6, 7, 8, 10, 11, 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, and 40) met the square footage requirement of 80 square feet (sq. ft. - unit of measurement) per resident in multiple resident rooms. The room size for these rooms had the potential to have inadequate space for resident care and mobility. Findings: During the recertification survey from 3/24/2025 to 3/28/2025, it was observed that the residents residing in the rooms with an application for variance had sufficient amount of space for residents to move freely inside the rooms. There was adequate room for the operation and use of wheelchairs, walkers, or canes. The room variance did not affect the care and services provided by nursing staff for the residents. On 3/26/2025, the Administrator submitted the application for the Room Variance Waiver for 36 resident rooms. The room variance letter indicated that these rooms did not meet the 80 square feet per resident requirement per federal regulation. The room waiver request showed the following: Room # Square Footage Number of Beds 1 147.53 2 2 147.53 2 3 147.53 2 4 147.53 2 5 147.53 2 6 147.53 2 7 156.41 2 8 147.53 2 10 147.50 2 11 147.50 2 12 147.50 2 (continued on next page)

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	03/28/2025

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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	14 157.71 2 15 157.71 2 16 157.71 2 17 157.71 2 18 215.54 3 19 212.74 3 20 212.74 3 21 235.33 3 22 211.2 3 23 211.2 3 24 211.2 3 26 150.70 2 27 150.70 2 28 150.70 2 29 150.70 2 30 150.70 2 31 150.70 2 32 213.72 3 33 213.72 3 34 213.72 3 35 213.72 3 36 213.72 3 37 213.72 3 38 213.72 3 (continued on next page)

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	03/28/2025

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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	39 213.72 3 40 213.72 3 The minimum requirement for a 2-bedroom should be at least 160 sq. ft. The minimum requirement for a 3-bedroom should be at least 240 sq. ft. During review of the room waiver letter, dated 3/26/2025, the room waiver letter indicated that each room listed on the Client Accommodation Analysis had no projections or other obstruction, which may interfere with free movement of wheelchairs and/or sitting devices. The letter indicated that there is enough space to provide for residents' care, dignity, and privacy, and that the rooms are in accordance with the special needs of the residents and would not have an adverse effect on residents' health and safety or impede the ability of any resident in the rooms to attain his or her highest practicable well-being. The letter indicated that all measures will be taken to assure the comfort of each resident. During review of the facility's policy and procedure titled, Resident Rooms, last reviewed on 1/15/2025, the policy and procedure indicated that resident bedrooms must be designed and equipped for adequate nursing care, comfort and privacy of residents. Resident bedrooms will measure at least 80 square feet per resident in multiple resident bedrooms and at least 100 square feet in single resident bedrooms.