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	05/22/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to: 1. Ensure the ice machine bin was kept clean. 2. Ensure drinks were maintained below 41 degrees Fahrenheit (F- unit for temperature). These failures had the potential to result in foodborne illness (illness caused by eating or drinking contaminated foods or beverages) for 84 of 87 residents who receive water and drinks from the facility. Findings: 1. During a concurrent observation and interview on 5/18/2026 at 8:30 a.m., with [NAME] 1 in the ice machine room, observed a dark greenish and black residue when the inside bin and door of the ice machine were wiped with a clean paper towel. [NAME] 1 stated the residue was dust and if ice gets contaminated it can cause residents' illnesses. During a concurrent observation and interview on 5/18/2026 at 2:56 p.m., with the Maintenance Supervisor (MS) in the ice machine room, observed a light brown and black residue collected when the inside of the ice bin, door molding, and the door were wiped with a clean paper towel. The MS stated it was dust, and the ice machine should be kept clean to prevent infections in residents. During a review of the Maintenance-Ice Machine Cleaning Schedule log, the ice machine was last cleaned on 4/24/2026. During a review of the facility's policy and procedure (P&P) titled, Ice Machine Cleaning Policy, revised 8/18/2025, the P&P indicated there should be a focus on cleaning the door molding and the lid of the machine to ensure there are no rust or calcium deposits. 2. During a concurrent observation and interview on 5/20/2026 at 12:26 p.m., with the Registered Dietitian (RD) in the kitchen, the temperatures of lunch drinks were tested: - The temperature of whole milk from cups in three trays was measured: the first tray's cup registered at 64 F, the second tray's cup at 50.5 F, and the third tray's cup at 43 F. - The temperature of apple juice from one cup tested was measured at 56.8 F. - The temperature of orange juice from one cup tested was measured at 62.4 F. The RD stated drinks served to residents need to be lower than 50 F and served within two hours if the temperature is in the danger zone (bacterial growth and/or toxin production can occur when food remains in temperatures between 41 F and 135 F for too long). The RD stated residents can get foodborne illness if the drinks are not kept within safe temperature levels. During an interview on 5/20/2026 at 12:56 p.m., with the Kitchen Supervisor (KS), the KS stated lunch drinks are pre-filled at 6:00 a.m. and kept refrigerated until 10:00 a.m., then put in the freezer until 11:30 a.m. when they start preparing for tray line (a system of food serving in which a tray is moved along an assembly line to ensure a resident gets their prescribed diet). The KS stated the kitchen staff maintain the drinks in ice trays during tray line, check temperature, and log temperature in the Food Temperature Chart. The KS stated the drinks stayed out too long and were not maintained under 41 F. During a concurrent interview and record review on 5/20/2026 at 2:35 p.m., with the RD, reviewed the facility's policy and procedure titled, Food Safety and Food Storage, revised 11/4/2024. The P&P indicated, Maintain food at proper temperature and out of the Danger Zone. The RD stated the lunch drinks were not maintained out of the danger zone.

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

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, and record review, the facility failed to ensure that a call light (a device used by a resident to signal his or her need for assistance from staff) was within reach for one of one sampled resident (Resident 97). ˆ This deficient practice had the potential to result in Resident 97 not being able to call for facility staff assistance and delay in the provision of necessary care and services which could negatively affect the residents' comfort and well-being.ˆ Findings:ˆ During a review of Resident 97's admission Record, the admission Record indicated the facility admitted Resident 97 on 5/12/2026 with diagnoses that included chronic obstructive pulmonary disease (COPDˆ-ˆlung disease that causes shortness of breathˆand narrowing of theˆairways), chronic (long-standing) congestive heart failure (CHF - progressive condition where the heart muscle becomes too weak or stiff to pump blood efficiently), and dependence on supplemental oxygen. During a review of Resident 97's Minimum Data Set (MDS - a resident assessment tool) dated 5/15/2026, the MDS indicated Resident 97 is able to make herself understood and understand others. The MDS indicated Resident 97 required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene, shower/bath self, putting on/taking off footwear, required partial/moderate assistance (helper does less than half the work) with personal hygiene, upper and lower body dressing. The MDS further indicated Resident 97 required substantial/maximal assistance with sit to stand, chair-bed-to chair transfer, and toilet/tub/shower transfer. During a review of Resident 97's History and Physical (H&P) dated 5/14/2026, the H&P indicated Resident 97 had the capacity to understand and make decisions. During a concurrent observation and interview on 5/18/2026 at 10:57 a.m., with the Director of Nursing (DON), Resident 97's call light was observed on the floor near the head of Resident 97's bed. The DON stated that the call light should always be within the resident's reach to allow residents to alert staff when assistance is needed. The DON stated that if the call light is inaccessible, care could be delayed. The DON stated that there's a potential for injury if the resident tried to get out of bed due to not being able to have access to the call light to call for help and also the potential for harm if the resident is having a change of condition and they cannot access help promptly. During a review of Resident 97's care plan (a document that outlines a resident's healthcare needs, goals, and the interventions planned to achieve those goals) titled, The resident is at risk for falls, initiated 5/13/2026, the care plan indicated an intervention to place the resident's call light within reach and encourage the resident to use it for assistance as needed. The care plan also indicated the resident needs prompt response to all request for assistance. During a review of the facility's policy and procedure (P&P) titled, Call Lights: Accessibility and Timely Response, last reviewed 1/14/2026, the P&P indicated, Staff will ensure the call light is within reach of resident and secured, as needed.The call system will be accessible to residents while in bed or other sleeping accommodations within the resident's room. During a review of the facility's P&P titled, Fall Prevention Program, last reviewed 1/14/2026, the P&P indicated, Fall interventions include, but not limited to:.call light and frequently used items are within reach.

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide two of two sampled residents (Resident 22 and Resident 54) quarterly financial statements. This failure had the potential to result in mismanagement of the residents' funds and to prevent the residents from making informed financial decisions regarding their finances. Findings: During a review of Resident 22's admission Record (front page of the chart that contains a summary of basic information about the resident), the admission Record indicated the facility admitted Resident 22 to the facility on 1/4/2020 with diagnoses including but not limited to hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (partial paralysis or weakness of one side of the body caused by brain damage), and gout (a painful form of arthritis that cause inflammation in the joints). During a review of the Minimum Data Set (MDS - a resident assessment tool), dated 2/23/2026, the MDS indicated Resident 22's cognition (the mental processes involved in acquiring, processing, storing, and retrieving information) was intact. During a review of Resident 22's History and Physical (H&P), dated 10/10/2025, the H&P indicated Resident 22 had capacity to understand and make own decisions. During an interview on 5/18/2026 at 11:55 a.m. with Resident 22, Resident 22 stated the facility had not provided quarterly financial statements for several months. During a review of Resident 54's admission Record, the admission Record indicated the facility originally admitted Resident 54 to the facility on [DATE] and readmitted on [DATE] with diagnoses including sequelae following unspecified cerebrovascular disease (a condition with unknown cause that affects blood vessels and blood supply to the brain often leading to brain damage), obstructive hydrocephalus (a blockage in the brain that prevents the normal flow of cerebrospinal fluid through brain passages), and presence of cerebrospinal fluid drainage device (a surgically implanted device to remove excess fluid from the brain). During a review of the MDS, dated [DATE], the MDS indicated Resident 54's cognition was moderately impaired. During a review of Review of Resident 54's H&P dated 4/6/2026, the H&P indicated Resident 54 did not have the capacity to understand and make decisions. During a concurrent interview and record review on 5/22/2026 at 1:03 p.m. with the Business Office Manager (BOM), the facility's policy and procedure (P&P) titled, Resident Trust Funds, last reviewed 1/14/2026, was reviewed. The P&P indicated the facility: -Provide a quarterly statement each quarter to each resident or resident representative (RP) reflecting all transactions and balances. -Date and document when the statement is provided. -Requests the signature of the resident or RP as proof of receipt of quarterly statement. -All reports printed and placed in a Patient Trust Binder. The BOM stated the facility did not follow the P&P by not providing Resident 54 and Resident 22 quarterly statements for the quarter period of 1/1/2026 to 3/31/2026. During an interview on 5/22/2026 at 1:51 p.m. with the Administrator, the Administrator stated quarterly statements should be provided to each resident or RP and the BOM office maintains records of quarterly statements given to residents or RP. During an interview on 5/22/2026 at 3:08 p.m. with Resident 54's RP, the RP stated the facility had not provided quarterly statements of Resident 54's account for about one year and is not aware of Resident 54's account balance.

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide two of two sampled residents (Resident 22 and Resident 54) receiving Medicaid (a joint federal and state program that provides free or low-cost health coverage to people with limited income and resources) benefits notification when the amount in the resident's account reached $200 less than the resource limit for one person, specified in section 1611(a)(3)(B) of the Act.This failure had the potential to result in the residents losing Medicaid eligibility. Findings: During a review of Resident 22's admission Record (front page of the chart that contains a summary of basic information about the resident), the admission Record indicated the facility admitted Resident 22 to the facility on 1/4/2020 with diagnoses including but not limited to hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (partial paralysis or weakness of one side of the body caused by brain damage), and gout (a painful form of arthritis that cause inflammation in the joints). During a review of the Minimum Data Set (MDS - a resident assessment tool), dated 2/23/2026, the MDS indicated Resident 22's cognition (the mental processes involved in acquiring, processing, storing, and retrieving information) was intact.During a review of Resident 22's History and Physical (H&P), dated 10/10/2025, the H&P indicated Resident 22 had capacity to understand and make own decisions. During an interview on 5/18/2026 at 11:55 a.m. with Resident 22, Resident 22 stated the facility had not provided quarterly financial statements for several months. During a review Resident 22's Resident Fund Statement, dated 1/1/2026 to 3/31/2026, the Resident Fund Statement indicated an account balance of $4,851.02. During a review of Resident 54's admission Record, the admission Record indicated the facility originally admitted Resident 54 to the facility on [DATE] and readmitted on [DATE] with diagnoses including sequelae following unspecified cerebrovascular disease (a condition with unknown cause that affects blood vessels and blood supply to the brain often leading to brain damage), obstructive hydrocephalus (a blockage in the brain that prevents the normal flow of cerebrospinal fluid through brain passages), and presence of cerebrospinal fluid drainage device (a surgically implanted device to remove excess fluid from the brain). During a review of the MDS, dated [DATE], the MDS indicated Resident 54's cognition was moderately impaired. During a review of Review of Resident 54's H&P dated 4/6/2026, the H&P indicated Resident 54 did not have the capacity to understand and make decisions. During a review Resident 54's Resident Fund Statement, dated 1/1/2026 to 3/31/2026, the Resident Fund Statement indicated an account balance of $4,423.84. During a concurrent interview and record review on 5/22/2026 at 1:03 p.m. with the Business Office Manager (BOM), the facility's policy and procedure (P&P) titled, Resident Trust Funds, last reviewed on 1/14/2026,ˆwas reviewed. The P&PˆindicatedˆthefacilitywillprovidewrittennotificationtorecipientsofMedicaidortheirResidentRepresentative(RP)whentheirResidentFundTrustbalanceapproach$200oftheresourcelimits.TheBOMstatedthefacilitydidˆnotfollowtheP&Ptoprovidenotification toResident22andResident54whentheirresourcelimitswereapproaching$2000;andResident22andResident54couldbeatriskoflosingMedicaidbenefits.ˆ

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, and record review, the facility failed to develop a comprehensive person-centered care plan (a document that summarizes a resident's needs, goals, and care/treatment) addressing the use of an arm splint (medical device that stabilizes a part of your body and holds it in place) for one of 18 sampled residents (Resident 7). This deficient practice had the potential to negatively affect the delivery of care and services. Findings:ˆ During a review of Resident 7's admission Record, the admission Record indicated the facility originally admitted Resident 7 on 11/29/2023 and re-admitted the resident on 4/16/2026 with diagnoses that included dementia (a progressive state of decline in mental abilities), pleural effusion (an abnormal buildup of excess fluid in the lungs), and need for assistance with personal care. During a review of Resident 7's Minimum Data Set (MDS - a resident assessment tool) dated 4/19/2025, the MDS indicated Resident 7 sometimes understood others and sometimes understands others. The MDS indicated Resident 7 was dependent (helper does all of the effort) with activities of living (ADL - routine activities such as bathing, dressing, and toileting a person performs daily). The MDS indicated Resident 7's was dependent for all mobility. During a review of Resident 7's History and Physical (H&P) dated 3/15/2026, the H&P indicated Resident 7 does not have the capacity to understand and make decisions. During a concurrent observation and interview on 5/19/2026 at 10:45 a.m., with Licensed Vocational Nurse 3 (LVN 3), observed Resident 7 with a blue device wrapped around Resident 7's right arm. LVN 3 stated the device applied to Resident 7's right arm was a splint. During a concurrent interview and record review on 5/21/2026 at 11:33 a.m., with the Director of Rehabilitation (DOR), reviewed Resident 7's care plans. The DOR stated Resident 7 had a right elbow splint as an intervention under the occupational therapy treatment. The DOR stated that Resident 7's right elbow splint and Occupational Therapy goals and interventions for Resident 7's right elbow splint were not documented in Resident 7's interdisciplinary care plan. During a concurrent interview and record review on 5/21/2026 at 1:42 p.m., with the Minimum Data Set Nurse (MDS Nurse), the MDS Nurse stated the purpose of the care plan is to list the residents' concerns, problems, and the goals and interventions for each identified concern or problem. The MDS Nurse stated a comprehensive care plan guides the resident's care. The MDS Nurse stated that Resident 7's right elbow splint was not in Resident 7's interdisciplinary care plan. The MDS Nurse stated that Resident 7's right elbow splint should have been in the interdisciplinary care plan for the care plan to be comprehensive. During an interview on 5/21/2026 at 4:05 a.m., with the Director of Nursing (DON), the DON stated that a comprehensive care plan is a complete care plan. The DON stated that not having Resident 7's right elbow splint in Resident 7's interdisciplinary care plan does not make Resident 7's care plan comprehensive. The DON stated that a complete and comprehensive care plan is important to ensure care teams are all working together towards providing the best care to the residents. During a review of the facility's policy and procedure (P&P) titled, Comprehensive Care Plans, last reviewed 1/14/2026, the P&P indicated, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident's rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identifies in the resident's comprehensive assessment.The comprehensive care plan will be prepared by an interdisciplinary team, that includes, but is not limited to: f. Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. Examples include, but are not limited to: iv. Licensed therapists.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review, the facility failed to ensure a resident unable to carry out activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily) received the necessary services to maintain neatly trimmed fingernails and toenails for one of two sampled residents (Resident 25). This deficient practice had the potential to negatively affect Resident 25's dignity. Findings: During a review of Resident 25's admission Record, the admission Record indicated the facility admitted Resident 25 on 2/17/2026 with diagnoses that included type two (2) diabetes (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), need for assistance with personal care, and muscle weakness. During a review of Resident 25's History and Physical (H&P) dated 2/18/2026, the H&P indicated Resident 25 had the capacity to understand and make decisions. During a review of Resident 25's Minimum Data Set (MDS, a resident assessment tool) dated 2/24/2026, the MDS indicated Resident 25 did have the capacity to make himself understood and understand others, and was dependent (helper does all the effort) on staff for activities such as toileting, dressing, bathing and personal hygiene. During a concurrent observation and interview on 5/18/2026 at 8:17 a.m., in Resident 25's room, Resident 25 stated the last time the podiatrist was at the facility, he was told he was not on the list to be trimmed. Resident 25 stated his fingernails, and toenails were too long, and his toenails were too yellow and thick and he is unable to care for them himself. Resident 25's fingernails and toenails appeared long, jagged, yellow and thick. Resident 25 stated only a podiatrist can cut his toenails because he has DM. Resident 25 stated he likes to be groomed especially his hair and his nails. During a concurrent observation and interview on 5/18/2026 at 8:33 a.m., with the Infection Preventionist (IP), observed Resident 25's fingernails and toenails. The IP stated Resident 25's fingernails and toenails were too long and the toenails appeared yellow and thick, especially the big toes. The IP stated the right big toe had what appeared to be an ingrown nail affecting the outside wall of the right big toe. During an interview on 5/22/2026 at 11:52 a.m., with the Director of Nursing (DON), the DON stated that having untrimmed or jagged nails can affect Resident 25's dignity because he is very alert and likes to be groomed. During a review of the facility's policy and procedure (P&P) titled, Resident Rights, last reviewed on 1/14/2026, the P&P indicated residents have a right to a dignified existence. During a review of the facility's P&P titled, Activities of Daily Living (ADLS), Supporting, last reviewed on 1/14/2026, the P&P indicated residents who are unable to carry out ADLs independently will receive the services necessary to maintain good nutrition, grooming, dressing, and personal and oral hygiene.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on interview and record review the facility failed to ensure residents received treatment and care in accordance with professional standards of practiceˆbyˆfailingˆto follow upˆon a reoccurring right big toe ingrown nail after a 30-day treatment from 4/2/26/ to 5/2/26ˆwhen on 5/18/26ˆthe residentˆhad an ingrown again on the same toenail without orders to treatˆfor one ofˆtwoˆsampled resident (Resident 25)ˆinvestigatedˆunderˆnon-pressure skin conditions.ˆ This deficient practice placedˆResident 25, who has a diagnosis of type 2 diabetesˆ(DM-a disorder characterized by difficulty in blood sugar control and poor wound healing),ˆat risk forˆinfection and pain.ˆ Findings: During a review of Residentˆ25's admission Record, the admission Recordˆindicatedˆthe facility admitted Residentˆ25ˆonˆ2/17/2026ˆwith diagnoses thatˆincludedˆtype 2 diabetesˆand need forˆassistanceˆwith personalˆcare and muscle weakness.ˆˆ During a review of Resident 25's History and Physical (H&P) dated 2/18/2026, the H&P indicated Resident 25 had the capacity to understand and make decisions. During a review of Residentˆ25's Minimum Data Set (MDS, a resident assessment tool), datedˆ2/24/2026, the MDS indicated Residentˆ25ˆdidˆhave the capacity to make himself understood and understand others, and was dependentˆ(helper does all the effort)ˆon staff for activities such as toileting, dressing,ˆbathingˆand personal hygiene.ˆ During a concurrent observation and interview onˆ5/18/2026ˆatˆ8:20 a.m. in Resident 25's room, Resident 25 was lying in bed watching television. Resident 25ˆstatedˆthe last time the podiatrist was at the facility, he was told he was not on the list to be trimmed. Resident 25ˆstatedˆthere was an ingrown toenail on his right big toe that came back but it only bothers him if someone puts pressure on it. Resident 25 stated it has been a very long time since he had any treatment to his right big toe, and he has had the ingrown toenail for at least a week or longer. Resident 25 stated he told staff but did not remember who he told. During a concurrent observation and interview onˆ5/18/2026ˆatˆ8:36ˆa.m. withˆthe Infection Preventionist (IP), the IP looked at Resident 25's feet andˆstated the right big toe hadˆwhat appeared to be anˆingrown nail affecting the outside wall of the right big toe.ˆThe IP stated there appeared to be some swelling and a dry crust on the left side of Resident 25's right big toe and needed to notify the doctor or podiatrist to get orders to provide treatment for it. The IP stated treatment should have started as soon as the symptoms came back and that there should have been follow-up after the treatment ended on 5/2/2026 by either getting an order to continue treatment or document it was healed, if fully healed. The DON further stated for residents with DM, licensed staff should be assessing their lower extremities for any wounds or suspected wounds daily and CNAs should be checking the resident's body for any wounds or discoloration when they are being showered or provided perineal (simple gentle cleaning of the genital area) care. During an interviewˆ5/22/2026ˆat 11:59 a.m.ˆwithˆthe Director of Nursing (DON), the DONˆstatedˆthat Resident 25 has diabetes and wounds such as ingrown toenails should be addressed as soon as possible. The DON stated the treatment nurses should have followed up after the orders to treat the same wound ended on 5/2/2026. During a review of the facility's P&P, titled Podiatry Services, last reviewed 1/14/2026, the P&P indicated, it is the policy of the facility to ensure residents receive proper treatment and care within professional standards of practice to maintain mobility and good foot health. During a review of the facility's P&P titled, Nursing Care of the Resident with Diabetes Mellitus, last reviewed 1/14/2026, the P&P indicated the purpose of these guidelines are to recognize, mange, and document the treatment complications commonly associated with diabetes . Foot complications may be associated with prolonged, poorly controlled diabetes.

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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. Based on observation, interview, and record review, the facility failed to ensure residents received care consistent with professional standards of practice to prevent pressure injuries/ulcers (PI/PU, injuries to the skin and underlying tissue resulting from prolonged pressure) by failing to ensure the low air loss mattress (LALM, a mattress designed to prevent and treat PIs) was on for one of four sampled residents (Resident 1). This deficient practice had the potential for the worsening of, or development of new PI/PUs to Resident 1. Findings: During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 1/30/2026 with diagnoses that included type two (2) diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), pressure ulcer of sacral region (the area at the base of your spine, just above the tailbone and between the hips), and 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 1's Minimum Data Set (MDS, a resident assessment tool), dated 5/9/2026, indicated Resident 1 was understood by others and was able to understand others and was dependent (helper does all the effort) on facility staff for toileting, bathing, lower body dressing and taking off/putting on footwear. The MDS further indicated Resident 1 had a PU/PI and was using a pressure-reducing device for his bed. During a review of Resident 1's Care Plan titled, At Risk for Development of PI, initiated on 1/31/26, the care plan indicated an intervention to use pressure reducing mattress. During a review of Resident 1's Order Summary Report, the Order Summary Report indicated an order for LALM for wound management. Charge Nurses to check proper placement and function. Setting according to resident's weight every shift. During a concurrent observation and interview on 5/18/2026 at 9:33 a.m., with Licensed Vocational Nurse 4 (LVN 4) in Resident 1's room, observed Resident 1 lying on his bed, flat with his LALM off. LVN 4 stated the LALM should always be on when the resident is in bed to help prevent new or worsening PI/PU. LVN 4 stated Resident 1 had a PU on his sacrum, and it was important for the LALM to be on and functioning. During an interview on 5/22/2026 at 1:37 p.m., with the Director of Nursing (DON), the DON stated Resident 1's LALM must be on at all times when he is in bed to prevent further breakdown. The DON stated the licensed staff is in charge of making sure the LALM is functioning properly and at the right setting according to weight. During a review of the facility's Policy and Procedure (P&P) titled, Pressure Injury Prevention Guidelines, last reviewed 1/14/2026, the P&P indicated to prevent pressure injuries to residents by repositioning and using pressure relieving /reducing and redistributing devices including but not limited to pressure relieving mattresses, wedges and pillows. The P&P further indicated when physician orders are present, the facility will follow the specific physician orders.

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	05/22/2026

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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. Based on observation, interview, and record review, the facility failed to develop and implement a person-centered care plan (a document that summarizes a resident's needs, goals, and care/treatment) that includes and supports dementia care needs for one of three sampled residents (Resident 7) with dementia. This deficient practice had the potential to negatively affect the delivery of services to residents living with dementia. Findings:ˆ During a review of Resident 7's admission Record, the admission Record indicated the facility originally admitted Resident 7 on 11/29/2023 and re-admitted the resident on 4/16/2026 with diagnoses that included dementia (a progressive state of decline in mental abilities), pleural effusion (an abnormal buildup of excess fluid in the lungs), and need for assistance with personal care. During a review of Resident 7's Minimum Data Set (MDS - a resident assessment tool) dated 4/19/2025, the MDS indicated Resident 7 sometimes understood others and sometimes understands others. The MDS indicated Resident 7 was dependent (helper does all of the effort) with activities of living (ADL - routine activities such as bathing, dressing, and toileting a person performs daily). The MDS indicated Resident 7's was dependent for all mobility. During a review of Resident 7's History and Physical (H&P) dated 3/15/2026, the H&P indicated Resident 7 does not have the capacity to understand and make decisions. During a concurrent observation and interview on 5/18/2026 at 10:20 a.m., with Resident 7, observed Resident 7 lying in bed. Resident 7 did not directly respond to questions and instead spoke about unrelated topics. During a concurrent interview and record review on 5/20/2026 at 10:27 a.m., with the Assistant Director of Nursing (ADON), reviewed Resident 7's care plans. The ADON stated that she reviewed Resident 7's care plans and did not find a care plan for dementia. The ADON stated Resident 7 had a diagnosis of dementia and should have a care plan for dementia interventions tailored to address Resident 7's needs. The ADON stated a care plan is the blue print and is the guide that shows the care for the resident with the specific condition and situation. The ADON stated residents with dementia have impaired cognitive status and require specific interventions and approach with their care. During an interview on 5/21/2026 at 4:05 p.m., with the Director of Nursing (DON), the DON stated a care plan is the foundation for a resident's overall plan of care. The DON stated that there should be a specific care plan for dementia, created specifically for the resident. The DON stated interventions within these care plans must address residents' cognitive needs. The DON stated that the care plan identifies problems, establishes goals and interventions, and facilitates evaluation to ensure intervention effectiveness, requiring adjustments when necessary. The DON stated that the absence of a care plan for dementia can result in delays in care and unmet resident needs. During a review of the facility's policy and procedure (P&P) titled, Dementia Care last reviewed 1/14/2026, the P&P indicated, It is the policy of this facility to provide the appropriate treatment and services to every resident who displays signs of, or is diagnosed with dementia, to meet his or her highest practicable physical, mental, and psychosocial well-being.The facility will assess, develop, and implement care plans through an interdisciplinary team (IDT) approach that includes the resident, their family, and/or resident representative, to the extent possible.

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	05/22/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to maintainˆinfection control measuresˆbyˆfailing to ensure Certified Nursing Assistant 1 (CNA 1) did not place her personal bag on a chair inside the resident's room for one of three sampled residents (Resident 48). This deficient practice placed Resident 48 at risk for exposure and possibly contracting infectious microorganisms. Findings:ˆ During a review of Resident 48's admission Record, the admission Record indicated the facility originally admitted Resident 48 on 4/2/2022 and re-admitted the resident on 1/16/2023 with diagnoses that included chronic (long-standing) congestive heart failure (CHF - progressive condition where the heart muscle becomes too weak or stiff to pump blood efficiently), rhabdomyolysis (a medical condition where damaged muscle tissue rapidly breaks down and dies), and immunodeficiency (body's defense system to fight infection is weakened) due to conditions. During a review of Resident 48's Minimum Data Set (MDS - a resident assessment tool) dated 3/17/2026, the MDS indicated Resident 48 can make herself understood and understand others. The MDS indicated Resident 48 was dependent (helper does all the effort) with shower/bath self, required substantial/maximal assistance (helper does more than half the effort) with lower body dressing, and required supervision or touching assistance (helper provides verbal cues and/or touching/steadying as resident completes activity) with oral hygiene, toileting hygiene, upper body dressing and eating. During a review of Resident 48's History and Physical (H&P) dated 4/9/2026, the H&P indicated Resident 48 had the capacity to understand and make decisions. During a concurrent observation and interview on 5/18/2026 at 11:35 a.m., with Resident 48, a female staff entered Resident 48's room and reached into a bag that was resting on a chair next to Resident 48's bed and quickly left the room. Resident 48 stated the bag belongs to her nurse. Resident 48 stated her nurse asked if she could leave her bag in Resident 48's room because Resident 48 stated, I guess they have some problems where staff can leave their things, not sure what problems. During an interview on 5/18/2026 at 12:00 p.m., with Resident 48 in the presence of the Director of Nursing (DON), Resident 48 stated the bag on the chair next to her bed is CNA 1's lunch bag. Resident 48 stated, She always comes and brings it here. She sometimes leaves her sweater too. During an interview on 5/18/2026 at 12:05 p.m., with the DON, the DON stated the facility provides a designated space where staff can store their belongings. The DON stated that staff should not keep any personal belongings in residents' rooms. The DON explained that staff's personal items brought into resident's room pose an infection control risk because the contents or cleanliness of those items are unknown. The DON stated that personal items may carry microorganisms that could potentially cause infections to the residents. During a review of Resident 48's care plan (a document that outlines a resident's healthcare needs, goals, and the interventions planned to achieve those goals) titled, The resident has impaired immunity related to chronic illness initiated 10/24/2025, the care plan indicated the resident is at risk for contracting infections due to impaired immune status. Keep the environment clean and people with infections away. During a review of the facility's policy and procedure (P&P) titled, Infection Prevention and Control Program, last reviewed 1/14/2026, the P&P indicated, The facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and help prevent the development and transmission of the communicable diseases and infections per accepted national standards and guidelines . All staff are responsible for following all policies and procedures related to the program.