

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055372	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/14/2024
NAME OF PROVIDER OR SUPPLIER Valley View Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 3111 Santa Anita Ave El Monte, CA 91733	
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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40438 Based on interview and record review, the facility failed to report an allegation of resident-to-resident abuse for two of four sampled residents (Residents 3 and 4) to the State Licensing and Certification Agency (responsible for the licensing or certification of health care facilities), the Ombudsman and to the local law enforcement within two hours, in accordance with the facility's Policy and Procedure (P&P) on Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating. This deficient practice had the potential for delayed investigation that would compromise Residents 3 and 4's safety with potential for further abuse. Findings: During a review of Resident 3's Admission Records (AR), the AR indicated Resident 3 was admitted to the facility on [DATE] with diagnoses that included acute heart failure (sudden condition when the heart can't pump enough oxygen to the body) and Diabetes Mellitus (a disease that result in too much sugar in the blood). During a review of Resident 3's Minimum Data Set (MDS, a standardized assessment and care screening tool) dated 6/13/2024, the MDS indicated Resident 3 had intact cognition (ability to understand) and required moderate assistance (helper does less than half the effort) with toileting, shower, and lower body dressing. During a review of Resident 4's AR, the AR indicated Resident 4 was admitted to the facility on [DATE] with diagnoses that included schizoaffective disorder (a mental condition that causes both a loss of contact with reality [psychosis] and mood problems) and anxiety (an unpleasant state of inner turmoil and fear). During a review of Resident 4's MDS dated [DATE], the MDS indicated Resident 4 had moderately impaired cognition, and required maximal assistance (helper does more than half the effort) with oral and toileting hygiene, upper body dressing and personal hygiene. During a review of the facility's Report of Suspected Dependent Adult/Elder Abuse Form (SOC 341), dated 6/10/2024, the SOC 341 indicated Resident 4 allegedly came in contact with Resident 3's left arm in the dining hall. The alleged resident to resident incident happened on 6/10/24 at 7:45 am. (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Fax Confirmations (FC) dated 6/10/2024, the FC indicated, the SOC 341 was faxed to the State Licensing and Certification Agency on 6/10/2024 at 12:07 pm. During an interview on 6/14/2024 at 10:47 am with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated, residents involved in altercations should be separated and deescalated immediately to prevent further harm. LVN 1 stated the resident-to-resident altercation incident should be reported to the local police department, ombudsman and the State Licensing and Certification Agency within two hours of the incident. During an interview on 6/14/2024 at 11:21 am with LVN 2, LVN 2 stated all staff were mandated reporters. LVN 2 stated, any incident or allegation of abuse should be reported timely to protect the residents against further harm in the facility. During an interview on 6/14/2024 at 12:34 pm with Registered Nurse Supervisor (RN Sup), the RN sup stated, incidents and allegations of abuse should be reported to the local police department, ombudsman and the State Licensing and Certification Agency within two hours of the incident and reporting should not be delayed for resident's safety and protection. During an interview on 6/14/2024 at 1:14 pm with the facility's Quality Assurance Nurse (QAN), QAN stated all incidents and allegations of abuse should be reported to the local police department, ombudsman and the State Licensing and Certification Agency within two hours of the incident to ensure the safety of the residents in the facility and to ensure the incident or allegation was investigated timely. During an interview on 6/14/2024 at 1:38 pm with the facility's Administrator (ADM), the ADM stated he was late in reporting the incident that happened between Residents 3 and 4 on 6/10/24. The ADM stated all incident and allegation of abuse should be reported to the local police department, ombudsman and the State Licensing and Certification Agency within two hours of the incident to assure residents were taken care of, incidents and allegations were investigated on time and residents were safe in the facility. During a review of the facility's P&P titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, dated September 2022, the P&P indicated, If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator or designee and to the other officials according to state law. The administrator, designee, or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: the state licensing/certification agency responsible for surveying/licensing the facility; the local/state ombudsman; the resident's representative; adult protective services; law enforcement officials; the resident's attending physician; and the facility medical director. Immediately is defined as within two hour of an allegation involving abuse.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 37198 Based on observation, interview, and record review the facility failed to ensure two of three sampled milk drinks were prepared at 41 degrees Fahrenheit (F, a unit used to measure temperature) or lower as indicated in the facility's Policy and Procedure (P&P) titled, Food Receiving and Storage. This deficient practice had the potential to cause foodborne illness (illness from eating contaminated food) to already compromised residents. Findings: During an observation in the facility's kitchen on 6/13/2024 at 12:19 PM, several four-ounce glasses of milk were on trays in meal tray carts ready to be served with the residents' lunch. Two of the three glasses of milk were randomly selected and observed to have a temperature higher than 41 degrees F. During a concurrent observation and interview on 6/13/2024 at 12:23 PM, with Dietary Aide 1 (DA 1), the temperature of one cup of milk was 56 degrees F. DA 1 stated the temperature should be 56 degrees F. DA 1 stated if the milk was not in the normal temperature range, residents would get sick from drinking the milk. DA 1 stated DA 1 would have to discard the milk if it was not in the normal temperature range. During a concurrent observation and interview on 6/13/2024 at 12:27 PM, with DA 1, the temperature of another cup of low-fat milk was 56.1 degrees F. DA 1 stated the milk was placed on the meal tray cart just recently. DA 1 stated DA 1 placed the milk on the tray when the dietary cook said it was time to serve. DA 1 stated DA 1 placed the drinks on the tray, one by one. During an interview on 6/13/2024 at 12:28 pm, with DA 2, DA 2 stated the temperature of the milk should be below 40 degrees F (around 35 - 36 degrees F.) DA 2 stated, if the temperature of the milk was 56 degrees F, the milk should be discarded. During an interview on 6/13/2024 at 3:25 pm, with the Dietary Supervisor (DS), DS stated the DA was supposed to check the temperature of the milk, 15 minutes before serving the milk. DS stated the temperature of the milk should be at a minimum of 32 degrees F and at a maximum of 41 degrees F. DS stated the milk should be discarded if the temperature was over 41 degrees F because it has gone into the potentially hazardous food temperature and residents could get sick. During a review of the facility's P&P, titled, Food Receiving and Storage, revised on 11/2022, the P&P indicated the danger zone means temperature above 41 degrees Fahrenheit (F) and below 135 degrees F that allow the rapid growth of pathogenic microorganisms that can cause foodborne illness. Potentially Hazardous Food (PHF) or Time/Temperature Control for Safety (TCS) Foods held in the danger zone for more than 4 hours (if being prepared from ingredients at ambient temperature) or 6 hours (if cooked and cooled) may cause a foodborne illness outbreak if consumed. PHF/TCS foods are stored at or below 41 degrees Fahrenheit, unless otherwise specified by law.		