STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055372	A. Building B. Wing	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley View Post Acute	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.

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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** Based on interview and record review, the facility failed to report an injury of unknown source to the California Department of Public Health (CDPH) for one of ten sampled residents (Resident 1). This failure resulted in the delay of notification to CDPH and had the potential for Resident 1 to be subjected to abuse while at the facility. During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that included cerebral infarction (damage to brain tissue caused by loss of blood flow to a part of the brain) and left side hemiparesis (weakness in the arm, leg, and face on one side of the body). During a review of Resident 1's History and Physical Examination (H&P, physician clinical evaluation and examination of the resident), dated 11/12/2025, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 4/16/2026, the MDS indicated Resident 1's cognitive skills (ability to think, learn, remember, use judgement, and make decisions) for daily decision making was severely impaired. The MDS indicated Resident 1 had short-term and long-term memory problems. The MDS indicated Resident 1 required maximal assistance (helper does more than half the effort to complete the activity) for eating, oral hygiene, upper body dressing, and personal hygiene. The MDS indicated Resident 1 was dependent on staff for toileting hygiene, showering/bathing, lower body dressing, and putting on and taking off shoes. The MDS indicated Resident 1 had impairment of range of motion on upper extremity (shoulder, elbow, wrist, hand) and lower extremity (hip, knee, ankle, foot) affecting one side of Resident 1's body. During a review of Resident 1's Change in Condition Evaluation (CIC), dated 5/29/2026, the CIC indicated Resident 1 had a scratch on upper lip and redness to eyes. During a review of Resident 1's CIC, dated 5/31/2026, the CIC indicated Resident 1 had redness around eyes on 5/29/2026 that changed to purple and yellow in color. During an interview on 6/3/2026 at 1:17 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated CNA 1 noticed bruises on Resident 1's face and CNA 1 did not know how Resident 1 got hurt. CNA 1 stated staff (in general) did not know how Resident 1 got hurt because it was not witnessed. During an interview on 6/3/2026 at 1:45 p.m. with Restorative Nursing Assistant (RNA) 1, RNA 1 stated during morning meeting on Sunday, 5/31/2026, they (nursing staff) discussed Resident 1's discoloration on the face. RNA 1 stated RNA 1 did not know how Resident 1 got hurt. RNA 1 stated Resident 1's discoloration on the face was not witnessed, it was discovered. During an interview on 6/3/2026 at 2:05 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 1 had bruising under both eyes and around upper lip. LVN 1 stated LVN 1 was informed about Resident 1's bruises during handoff report. LVN 1 stated the nurse from previous shift observed Resident 1's bruises but did not witness Resident 1 getting hurt. During an interview on 6/4/2026 at 9:58 a.m. with CNA 2, CNA 2 stated CNA 2 observed bruises on Resident 1's right forearm. CNA 2 stated CNA 2 did not know how Resident 1 got the bruises. CNA 2 stated no one had witnessed how Resident 1 got hurt. During an interview on 6/4/2026 at 2:42 p.m. with Director of Nursing (DON), the DON stated an injury of unknown source was when an injury occurred and staff (in general) did not know how it happened. (continued on next page)

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	The DON stated that when there was injury of an unknown source, the facility must report it to CDPH and conduct an investigation to find out how the resident got hurt. The DON stated after facility's investigation, the facility determined Resident 1's injuries were due to Resident 1 hitting the bedrail because that was normal behavior for Resident 1 and the incident was not reported to CDPH. The DON stated staff (in general) did not witness Resident 1 hurt Resident 1's face. The DON stated the bruises were discovered and reported to licensed nurses. During a review of the facility's policy and procedure (P&P) titled, Investigating Resident Injuries, dated 4/2026, the P&P indicated all resident injuries were investigated. The P&P indicated descriptions in the medical record must be objective and sufficiently detailed and should not speculate about causes. The P&P indicated if an incident/accident was suspected, nursing would complete the facility-approved accident/incident form. The P&P indicated an injury of unknown source was an injury that met both of the following conditions:The source of the injury was not observed by any person, or the source of the injury could not be explained by the resident.The injury is suspicious because of:The extent of the injury, the location of the injury, or the number of injuries observed at one particular point on time, or the incidence of injuries over time. During a review of facility's P&P titled, Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, dated 4/2026, the P&P indicated all reports of resident abuse (including injuries of unknown origin) are reported to local, state, federal agencies and thoroughly investigated by the facility management. The P&P indicated findings of all investigations are documented and reported, and 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 and to other officials according to state law. The P&P indicated the administrator or the individual making the allegation immediately reports his or her suspicion to the state licensing/certification agency responsible for survey/licensing the facility. The P&P indicated immediately was defined as a. within two hours of an allegation involving abuse or result in serious bodily injury orb. within 24 hours of an allegation that does not involve abuse or result in serious bodily injury

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a care plan (summary of a person's health condition, care needs, treatments, goals of treatment, and specific interventions for each identified condition or care need) for one of ten sampled residents (Resident 1) when: 1. There was no care plan regarding Resident 1's fall on 5/3/2026 found in Resident 1's medical record. 2. There was no care plan regarding Resident 1's behavior of getting Resident 1's arm stuck in the bed rail found in the Resident 1's medical record. These failures had the potential for Resident 1 not receiving appropriate care and services.During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that included cerebral infarction (damage to brain tissue caused by loss of blood flow to a part of the brain) and left side hemiparesis (weakness in the arm, leg, and face on one side of the body). During a review of Resident 1's History and Physical Examination (H&P, physician clinical evaluation and examination of the resident), dated 11/12/2025, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 4/16/2026, the MDS indicated Resident 1's cognitive skills (ability to think, learn, remember, use judgement, and make decisions) for daily decision making was severely impaired. The MDS indicated Resident 1 had short-term and long-term memory problems. The MDS indicated Resident 1 required maximal assistance (helper does more than half the effort to complete the activity) for eating, oral hygiene, upper body dressing, and personal hygiene. The MDS indicated Resident 1 was dependent on staff for toileting hygiene, showering/bathing, lower body dressing, and putting on and taking off shoes. The MDS indicated Resident 1 had impairment of range of motion on upper extremity (shoulder, elbow, wrist, hand) and lower extremity (hip, knee, ankle, foot) affecting one side of Resident 1's body. During a review of Resident 1's Change in Condition Evaluation (CIC), dated 5/3/2026, the CIC indicated Resident 1 was found sitting on the floor and suffered abrasions to Resident 1's midback. During a review of Resident 1's electronic medical record, there was no care plan regarding Resident 1's fall on 5/3/2026 found in Resident 1's medical record. During a review of Resident 1's Nursing Progress Notes (NPNs), dated 5/28/2026 to 5/30/2026, the NPNs indicated Resident 1 had a behavior of putting arm in bed rail. During a review of Resident 1's Doctor Progress Note (DPN), dated 5/28/2026, the DPN indicated Resident 1 exhibited behavior of wrapping Resident 1's arms around side rails. During a review of Resident 1's electronic medical record, there was no care plan regarding Resident 1's behavior of wrapping Resident 1's arm around the bed rail found in the medical record. During an interview on 6/4/2026 at 1:50 p.m. with the Director of Nursing (DON), the DON stated a care plan was used to initiate care and to identify issues that a resident has. The DON stated resident health problems, goals and interventions are implemented in the care plan. The DON stated it was important to develop a care plan to make sure residents received care and treatments necessary for their health issues. The DON stated if something did not get care planned, staff would not be aware of resident health issues. During an interview on 6/4/2026 at 2:22 p.m. with the DON, the DON stated Resident 1 had a behavior of placing Resident 1's right arm through the bed rail. The DON stated staff (licensed nurses) should have developed a care plan for Resident 1's repetitive behavior of getting Resident 1's arm stuck in the bed rail. The DON stated a care plan was required to assist nursing staff on how to handle future behaviors.During a review of facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, dated 4/2026, the P&P indicated the comprehensive person-centered care plan:a. Included measurable objectives and time framesb. Described the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure one of ten sampled residents (Resident 1) received care and services to prevent accidents when: 1. A Fall Risk Assessment (evaluation conducted to predict the likelihood that a resident will fall) was not completed after Resident 1 had a fall on 5/3/2026. 2. Resident 1 was not assessed by Rehabilitation Department (unit dedicated to help individuals restore physical, mental, cognitive, or vocational abilities lost due to disease, injury, or surgery) after Resident 1's fall on 5/3/2026. 3. Change of Condition (COC, a sudden clinically important deviation in the resident's health or functioning that requires further assessments and interventions) Evaluation was completed when Resident 1's arm got stuck in bed rail.These deficient practices placed Resident 1 at risk for injuries from accidents and had the potential for Resident 1 not receiving appropriate care and services to prevent accidents. During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that included cerebral infarction (damage to brain tissue caused by loss of blood flow to a part of the brain) and left side hemiparesis (weakness in the arm, leg, and face on one side of the body).During a review of Resident 1's History and Physical Examination (H&P, physician clinical evaluation and examination of the resident), dated 11/12/2025, the H&P indicated Resident 1 did not have the capacity to understand and make decisions.During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 4/16/2026, the MDS indicated Resident 1's cognitive skills (ability to think, learn, remember, use judgement, and make decisions) for daily decision making was severely impaired. The MDS indicated Resident 1 had short-term and long-term memory problems. The MDS indicated Resident 1 required maximal assistance (helper does more than half the effort to complete the activity) for eating, oral hygiene, upper body dressing, and personal hygiene. The MDS indicated Resident 1 was dependent on staff for toileting hygiene, showering/bathing, lower body dressing, and putting on and taking off shoes. The MDS indicated Resident 1 had impairment of range of motion on upper extremity (shoulder, elbow, wrist, hand) and lower extremity (hip, knee, ankle, foot) affecting one side of Resident 1's body. During a review of Resident 1's COC, dated 5/3/2026, the COC indicated Resident 1 was found sitting on the floor and suffered abrasions to Resident 1's midback. During a review of Resident 1's electronic medical record, there was no Fall Risk Assessment by Nursing Department and/or Rehabilitation Department after Resident 1 fell on 5/3/2026, found the in the medical record. During a review of Resident 1's electronic medical record, there was no COC regarding Resident 1's right arm getting stuck in the bed rail found in the medical record.During an interview on 6/3/2026 at 1:17 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated CNA 1 discovered Resident 1 had the resident's right arm stuck in the gaps of the bed rail. CNA 1 stated a licensed nurse (unidentified) had to remove Resident 1's right arm out of the bed rail. CNA 1 stated after Resident 1's right arm was removed, CNA 1 noticed Resident 1's right forearm had red marks. CNA 1 stated Resident 1 always placed Resident 1's arm in the bed rail. CNA 1 stated Resident 1 required assistance to get arm out of the bed rail and that was the reason why CNA 1 called a licensed nurse.During an interview on 6/3/2026 at 1:52 p.m. with Licensed Vocational Nurse (LVN) 1, LVN1 stated Resident 1 moved a lot in bed and had the ability to place Resident 1's arm through gaps in the bed rail. LVN 1 stated Resident 1 often placed Resident 1's arm through the gaps in the bed rail. LVN 1 stated LVN 1 observed Resident 1 had redness to right forearm.During an interview on 6/4/2026 at 9:58 a.m. with CNA 2, CNA 2 stated Resident 1 had a fall last month (May 2026). CNA 2 stated CNA 2 was informed Resident 1 was found sitting on the floor by Resident 1's bed. CNA 2 stated Resident 1 constantly placed arm in bed rail. CNA 2 stated CNA 2 observed bruises on Resident 1's right arm.During an interview on 6/4/2026 at 11:40 a.m. with Director of Rehabilitation (DOR), the DOR stated a Post Fall Screen (evaluation (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	conducted by a physical or occupational therapist to identify new physical impairments, functional decline, or a change in status following a resident fall) had to be completed by the Rehabilitation Department after a resident fall. The DOR stated a fall was when a resident's buttocks, knees or body touched the floor. The DOR stated a Fall Risk Assessment was required after a resident's fall to make sure the resident did not suffer any injury that would be harmful to the resident. The DOR stated after completing the assessment, the DOR would be able to refer the resident to required rehabilitation services. The DOR stated if a Post Fall Screen was not completed there would be a risk in overlooking injuries, fractures and pain and interventions would not be implemented. The DOR stated DOR was not informed about Resident 1's fall and the Rehabilitation Department should have been notified.During an interview on 6/4/2026 at 1:50 p.m. with Director of Nursing (DON), the DON stated a change of condition was when something unusual happened to a resident, something that was not resident's baseline. The DON stated it was important to document all changes of condition to inform staff what is going on with residents. The DON stated if changes of condition did not get documented there was a risk of further decline, staff would not be aware of residents' situation, and the residents would not receive the appropriate care and treatment. The DON stated Resident 1 required COC documentation for when Resident 1's arm got stuck on bed rail because Resident 1 sustained redness to right arm.During an interview on 6/4/2026 at 2:13 p.m. with DON, the DON stated a Fall Risk Assessment was completed on admission, after a fall and quarterly. The DON stated a Fall Risk Assessment was completed to assess a resident's risk in falling. The DON stated if a Fall Risk Assessment was not completed staff would not implement interventions and would not know resident's current risk in falling. The DON stated Resident 1 did not have a fall, Resident 1 was found sitting on the floor. The DON stated staff did not observe Resident 1 get off the bed and land on the floor, so Resident 1 did not fall. The DON stated Resident 1 was not on DON's top list for falls because Resident 1 was able to get off the bed. The DON stated finding Resident 1, who required staff assistance for all activities of daily living, on the floor was not considered a fall and that was why Resident 1 did not have a Fall Risk Assessment. The DON stated Resident 1 was found sitting on the floor and it was not treated as a fall and that was why Rehabilitation Department was not notified. The DON stated when Resident 1 was found sitting on the floor Resident 1 sustained abrasions on Resident 1's back.During a review of facility's Policy and Procedure (P&P) titled, Change in a Resident's Condition or Status, dated 4/2026, the P&P indicated the nurse would record in resident's medical record information relative to changes in the resident's medical/mental condition or status. During a review of facility's P&P titled Falls and Fall Risk, Managing, dated 4/2026, the P&P indicated when a resident was found on the floor, a fall is considered to have occurred. During a review of facility's P&P titled Fall Risk Assessment, dated 4/2026, the P&P indicated nursing staff, in conjunction with attending physician, consultant pharmacist, therapy staff, and others, will seek to identify and document resident risk factors for falls and establish a resident centered falls prevention plan based on relevant assessment information.