

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 05/24/2024
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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40913 Based on observation, interview, and record review, the facility failed to notify the physician of a change in skin condition and follow its policies and procedures titled Skin Conditions for one of one sampled resident (Resident 18). This deficient practice had the potential for the facility to not implement the necessary management and worsen Resident 18's skin condition. Findings: During a review of Resident 18's Admission Record (AR), the AR indicated the facility admitted the resident on 1/10/2020, with diagnoses that included hemiplegia (paralysis to one side of the body) and hemiparesis (weakness to one side of the bed) following cerebral infarction (stroke,) and aphasia (inability to express words or nonverbal equivalent of words.) During a review of Resident 18's Minimum Data Set (MDS - a standardized assessment and care planning tool) dated 5/18/2024, the MDS indicated the resident had moderately impaired cognition (ability to understand) and required maximal assistance (helper lifts or holds trunk or limbs and provides more than half the effort) with showers and toileting and moderate assistance (helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with chair/bed-to-chair transfers. During an observation on 5/21/2024 at 4:17 pm, Resident 18 showed to the surveyor a small scab on the side of his upper abdomen. Resident 18 was not able to respond verbally to question and kept repeating the word [NAME]. During a concurrent record review of Resident 18's medical record and interview with the facility's Wound Care Nurse (WCN) on 5/23/2024 at 3:30 pm, there was no change of condition or documented evidence that there was a new skin condition or an existing skin condition for Resident 18. The WCN stated there was no documentation that there was a skin condition and there was no order for a skin treatment for Resident 18. During an interview on 5/23/2024 at 3:35 pm, Certified Nursing Assistant 1 (CNA 1) stated he reported to the Interim Director of Nursing (IDON) regarding Resident 18's complaint of itching on the skin on his left abdomen. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 5/23/2024 at 3:40 pm, there were multiple red raised rashes on the side of Resident 18's abdomen, one to two inches from the armpit down to the hip area. Resident 18 was scratching the area where the rashes were. The WCN confirmed the rashes were multiple raised red rashes. During an interview on 5/23/2024 at 3:45 pm, the WCN stated it was important to notify the physician regarding any new skin condition of the resident to ensure the resident gets the treatment and for the physician to determine the cause of the rash. During an interview on 5/24/2024 at 9:30 am with the Infection Prevention Nurse (IPN- a nurse who helps prevent and identify the spread of infectious disease in the healthcare environment), the IPN stated the facility placed Resident 18 on contact precautions for shingles and placed Resident 18's roommate in a separate room on contact precautions for possible exposure to shingles. During an interview on 5/24/2024 at 9:43 am, the IDON stated when CNA 1 reported the skin condition to her, she endorsed it to Licensed Vocational Nurse 5 (LVN 5) to follow up. The IDON stated it was important to assess the rash and immediately notify Resident 18's medical doctor (MD). During a phone interview on 5/24/2024 at 10:00 am, LVN 5 stated the IDON reported to her Resident 18's skin condition and she endorsed the concern to Quality Assurance Nurse 1 (QAN 1) because LVN 5 was doing medication pass at that time. During an interview on 5/24/2024 at 1:25 pm, Quality Assurance Nurse 1 stated there was no communication from LVN 5 regarding Resident 18's new skin condition. QAN 1 stated the licensed nurses would use the communication board on the computer to communicate any change of condition, appointments and any endorsements related to patient care. QAN 1 stated, the licensed nurses can read the communication board for any endorsements. QAN 1 stated there was no endorsement given to her regarding Resident 18's new skin condition on the communication board. QAN 1 stated there was a section on the computer for the Certified Nursing Assistants to document any changes in condition on the Stop and Watch and it could be viewed by the licensed nurses. During an interview on 5/24/2024 at 1:43 pm, CNA 2 stated she saw Resident 18's rash yesterday when she was assisting Resident 18 change his clothes and observed the rash but she thought it was an existing skin condition. During an interview on 5/24/2024 at 1:51 pm, Resident 18's MD stated he had just now visually assessed the rash and diagnosed the rash as contact dermatitis and stated he had instructed the nurses to discontinue contact isolation. During a review of the facility's undated Policy and Procedure (P&P) titled Skin Conditions, the P&P indicated nursing assistants will check resident's skin on scheduled shower days and shall report any skin integrity impairment to the licensed nurse to follow up. The licensed nurse will observe the reported impairment. The P&P indicated the licensed nurse will notify the physician of skin impairment for orders and follow-up treatment and notify resident or resident representative of the change in the resident's skin status. The P&P indicated the licensed nurse will make an entry on resident's care plan as well as on the licensed nurse progress notes.		

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40037 Based on interview and record review, the facility failed to provide notification to Ombudsman (an individual who serves as an advocate for patients) of the facility-initiated discharge for one of three sampled residents (Resident 65). This failure had the potential to result in resident being inappropriately discharged . Findings: During a review of Resident 65's Admission Record indicated Resident 65 was admitted on [DATE], with diagnoses that included metabolic encephalopathy (a problem in the brain caused by a chemical imbalance in the blood) and acute metabolic acidosis (a condition in which acids build up in the body). During a review of Resident 65's Minimum Data Set (MDS, a resident assessment and care screening tool) dated 4/8/2024, the MDS indicated Resident 65 had moderately impaired cognition (ability to understand). The MDS indicated Resident 65 was dependent (helper does all of the effort, resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity) for oral hygiene, dressing and personal hygiene. During a review of Resident 65's Notice of Proposed Transfer/Discharge (NPT) dated 3/19/2024, the NPT indicated Resident 65 was transferred to an acute care hospital on 3/19/2024. During a review of Resident 65's another NPT dated 4/29/2024, the NPT indicated Resident 65 was transferred to an acute care hospital on 4/29/2024. During an interview and concurrent record review on 5/22/2024 at 10:25 am, Quality Assurance Nurse 2 (QA 2) stated, there was no documentation indicating the NPT for acute care hospital transfer for Resident 65 on 3/19/2024 and 4/29/2024 was provided to Ombudsman. QA 2 stated, the facility provided the notification to the Ombudsman by faxing the NPT to the Ombudsman's office. QA 2 stated, after the NPT was faxed to the Ombudsman's office, the facility should receive a confirmation of the fax and kept in the resident's record. QA 2 stated, the Ombudsman notification upon resident transfer to an acute care hospital was part of the regulation requirement, so the Ombudsman would be aware what happened to the residents. During a review of the facility's Policy and Procedure (P&P) titled Transfer or Discharge, Emergency, revised 8/2018, the P&P indicated Should it become necessary to make an emergency transfer or discharge to a hospital or other related institution, the facility will implement the following procedures: others as appropriate or as necessary. During an interview on 5/23/2024 at 11:30 am, QA 2 stated the verbiage others as appropriate or as necessary in the facility's Transfer or Discharge, Emergency policy indicated notification to the Ombudsman.		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40913 Based on observation, interview, and record review, the facility failed to provide one to one activity to two of two sampled residents (Residents 33 and 34) for five consecutive days (May 20, 2024 to May 24, 2024) in accordance with the residents' plan of care. These deficient practices had the potential to result to boredom or loneliness which could affect the physical, emotional, and psychosocial well-being of Residents 33 and 34. Findings: a. During a review of Resident 33's Admission Record (AR), the AR indicated the facility admitted the resident on 5/5/2023, with diagnoses that included hemiplegia (paralysis to one side of the body) and hemiparesis (weakness to one side of the body) following cerebral infarction (stroke) and dementia (long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily functioning). During a review of Resident 33's untitled care plan initiated on 10/9/2023, the care plan indicated the resident needed 1:1 activity visit to provide social interaction and mental/sensory stimulation. The care plan interventions indicated to provide 1:1 activity visit, incorporating topics meaningful to Resident 33 including music, hands lotion, aromatherapy, tv programs, sensory stimulation games and social interactions. During a review of Resident 33's Minimum Data Set (MDS - a standardized assessment and care planning tool) dated 2/20/2024, the MDS indicated the resident had severely impaired cognition (ability to understand). The MDS's Staff Assessment of Daily and Activity Preference for Resident 33 was not completed and left blank. During multiple observations on 5/23/2024: At 9:14 am, Resident 33 was sleeping. At 10:10 am, Resident 33 was sleeping. At 11:05 am, Resident 33 was sleeping. At 12:51 pm, Resident 33 was assisted with lunch. b. During a review of Resident 34's AR, the AR indicated the facility admitted the resident on 6/17/2021 with diagnoses including traumatic brain injury and quadriplegia (paralysis of both upper and lower extremities.) (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 34's untitled care plan initiated on 11/30/2023, the care plan indicated the resident was dependent on staff for meeting emotional, intellectual, physical, and social needs related to cognitive deficits and immobility. The care plan indicated staff will continue to do 1:1 visit to provide sensory stimulation and reality awareness. The care plan goal indicated Resident 34 will attend/participate in activities of choice such as television, listening to music, napping and family visits. During a review of Resident 34's MDS dated [DATE], the MDS indicated the resident had severe cognitive impairment and was dependent with all activities of daily living and bed mobility. The MDS's Staff Assessment of Daily and Activity Preference for Resident 34 was not completed and left blank. During an observation on 5/2024/24 at 3:35 pm, Resident 34 was lying in bed, awake and made eye contact. During a concurrent observation and interview on 5/24/2025 at 3:00 pm, the facility's Activities Assistant (AA) stated she was the only staff assigned to do activities but there were other non-activity staff assisting with group activities. The AA stated she would visit the residents who were staying in their rooms for in room activities for 10 minutes in the morning and around lunchtime. The AA stated she would spend five minutes with each resident on the list. During a concurrent interview and review of the facility's undated document titled Activity Department One to One Program and Documentation the document did not indicate Residents 33 and 34 were scheduled to have activities for one week from Sunday to Saturday and AA stated she did not know the reason why the Activities Director did not write any activities for Residents 33 and 34. The AA stated she did not provide one to one activity to Residents 33 and 34 because they were not on the schedule. The AA stated she followed the instructions on the document and provided one to one activity to the other 12 residents on the list. The Activity Department One to One Program and Documentation indicated a one-on-one structured program shall be provided to those residents that are comatose/bed-bound, room-bound, and/or physically unable to leave their room to attend activities. The document indicated the purpose of the one-to-one activities would be to ensure that each resident's activity needs and interests were met. During a review of the facility's Policy and Procedure (P&P) titled Activity, revised February 2023, the P&P indicated the activity evaluation was used to develop an individual activities care plan that will allow the resident to participate in activities of his/her choice and interest.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48905 Based on interview and record review, that facility failed to turn and reposition one of one sampled resident (Resident 58) every two hours on 5/17/2024, 5/20/2024, and 5/22/2024. This failure had the potential for Resident 58 to sustain skin breakdown and possibly, develop a pressure injury (caused when an area of skin is placed under pressure and breaks down the skin and underlying tissue). Findings: During a review of Resident 58's AR, the AR indicated Resident 58 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included hemiplegia (unable to move or control affected muscles) and hemiparesis (one-sided weakness) after cerebral infarction (disrupted blood flow to the brain), aphasia (full or partial loss of language abilities), and atelectasis (collapse of part or all of a lung). During a review of Resident 58's untitled care plan (CP) dated 12/24/2021, the CP indicated Resident 58 was at risk for skin breakdown and for staff to assist in repositioning Resident 58 every two hours and as needed. During a review of Resident 58's History and Physical (H&P, formal document of a medical provider's examination of a patient) dated 11/20/2023, the H&P indicated Resident 58 was able to understand and make decisions. During a review of Resident 58's Braden Scale Risk Assessment (BSRA, tool used to rate the risk of developing a pressure ulcer) dated 3/23/2024 at 9:01 AM, the BSRA indicated Resident 58 was high risk for developing a pressure sore due to limited ability to respond to verbal commands, very moist skin, very limited mobility (ability to change and control body position) and being confined to bed. During a review of Resident 58's Minimum Data Set (MDS, a standardized assessment and care planning tool) dated 3/28/2024, the MDS indicated Resident 58 required maximal assistance with rolling left and right. The MDS indicated Resident 58 was at risk for developing pressure injuries and was on a turning and repositioning program. During a concurrent interview and record review on 5/22/2024 at 12:19 PM with Licensed Vocational Nurse 1 (LVN 1), Resident 58's form titled Tasks was reviewed. The task form indicated Resident 58 needed to be turned and repositioned every two hours. The task form indicated Resident 58 was not turned or repositioned on 5/17/2024 from 4:00 PM to 10:00 PM, on 5/20/2024 from 4:00 AM to 6:00 AM, and on 5/22/2024 at 6:00 AM. LVN 1 stated Resident 58 was dependent on staff for turning as Resident 58 was unable to turn by herself. LVN 1 stated Resident 58 was not turned and repositioned on 5/17/2024 from 4:00 PM to 10:00 PM, on 5/20/2024 from 4:00 AM to 6:00 AM, and on 5/22/2024 at 6:00 AM. LVN 1 stated Resident 58 was high risk for skin breakdown and Resident 58 had a history of pressure injuries on the sacrum (tailbone) in the past. LVN 1 stated Resident 58 needed to be repositioned every two hours and as needed. LVN 1 stated, the risk of not turning and repositioning could cause skin breakdown for Resident 58. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/23/2024 at 3:33 PM with the Interim Director of Nursing (IDON), the IDON stated Resident 58 was high risk for skin breakdown because Resident 58 was unable to move by herself. IDON stated turning and repositioning every two hours was not documented for Resident 58 on 5/17/2024 from 4:00 PM to 10:00 PM, on 5/20/2024 from 4:00 AM to 6:00 AM, and on 5/22/2024 at 6:00 AM. and would indicate that the task was not completed. The IDON stated, not turning and repositioning residents every two hours would place the residents at risk of skin breakdown and possibly develop a pressure injury. During a review of the facility's Policy and Procedure (P&P) titled Repositioning revised 5/2013, the P&P indicated residents who are in bed should be on at least every two-hour repositioning schedule.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48905 Based on observation, interview, and record review, the facility failed to provide wound care treatment daily as ordered for one of one sampled resident (Resident 289). Wound care treatment was ordered for Resident 289 on 5/16/2024 and was started on 5/18/2024. This failure had the potential for Resident 289's left heel unstageable pressure ulcer (type of bed sore that occurs due to prolonged pressure on a specific area on the skin and is covered by eschar [dry, black, hard dead tissue]) to worsen. Findings: During a review of Resident 289's Admission Record (AR), the AR indicated Resident 289 was admitted to the facility on [DATE] with diagnoses that included cellulitis (bacterial skin infection when the skin becomes swollen, warm, and painful to the touch), peripheral vascular disease (blood vessels become narrow, blocked, or spasm), and hypertension (high blood pressure). During a review of Resident 289's Minimum Data Set (MDS, a standardized assessment and care planning tool) dated 5/6/2024, the MDS indicated Resident 289's cognitive ability (ability to think, learn, and process information) was moderately impaired. The MDS indicated Resident 289 was at risk for developing pressure ulcer/injuries and was admitted to the facility with one unstageable pressure ulcer. During a review of Resident 289's Order Details (OD) dated 5/16/2024, the OD indicated Resident 289 had a physician's order to receive treatment for the left heel unstageable pressure injury every other day and as needed with instructions for every day shift, every day. During a concurrent observation and interview on 5/21/2024 at 9:00 AM with Resident 289, Resident 289's left heel was in a padded boot. Resident 289 stated the padded boot was for Resident 289's left foot wound. Resident 289 stated Resident 289 received treatment for the left heel, mostly every day. During a concurrent interview and record review on 5/23/2024 at 12:30 PM with the facility's Wound Care Nurse (WCN), Resident 289's Treatment Administration Record (TAR) dated 5/1/2024 to 5/31/2024 was reviewed. Resident 289's TAR indicated wound care treatment of the left heel on 5/16/2024 and 5/17/2024 were blank. The WCN stated treatment for the left heel unstageable pressure injury needed to be done daily. The WCN stated the directions on the OD indicated the treatment needed to be done every day and not every other day. The WCN stated if the treatment record for Resident 289 for 5/16/2024 and 5/17/2024 were blank, treatment was not done, as ordered. The WCN stated wound care treatment was ordered on 5/16/2024 and the wound treatment was delayed as indicated in Resident 289's TAR that Resident 289 received wound treatment on 5/18/2024. The WCN stated delaying wound care treatment to Resident 289's wound could possibly worsen the wound or the wound could get infected. (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/23/2024 at 2:56 PM with the Quality Assurance Nurse (QA Nurse), the QA Nurse stated the QA Nurse incorrectly entered the MD order as every other day and not every day. The QA Nurse stated the MD order was supposed to be dressing changes for the left heel unstageable pressure ulcer every day from 5/16/2024 to 5/20/2024, then every other day starting on 5/21/2024. The QA Nurse stated there were two blank spaces on Resident 289's TAR. QA Nurse stated, wound treatment for Resident 289 was not done on 5/16/2024 and 5/17/2024. The QA Nurse stated the risk of not inputting the physician's order correctly resulted to missed treatment. During an interview on 5/23/2024 at 3:52 PM with the Interim Director of Nursing (IDON), the IDON stated 5/16/2024 and 5/17/2024 were blank on Resident 289's TAR. The IDON stated blank spaces in the TAR indicated the wound treatment for Resident 289's left heel unstageable pressure injury was not done. IDON stated the risk of not completing wound care treatment as ordered was that the wound could get worse or get infected. During a review of the facility's Policy and Procedure (P&P) titled, Medication Orders revised 11/2014, the P&P indicated when recording treatment orders, specify the treatment, frequency and duration of the treatment.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 14330 Based on observation, interview and record review, the facility failed to provide appropriate care to prevent urinary tract infection ([UTI]an infection in any part of the urinary system [kidneys, bladder, ureters, and urethra]) for one of two sampled residents (Resident 1) on indwelling catheter (collects urine by attaching to a drainage bag) by failing to ensure staff monitor Resident 1's urine output and notify the physician promptly for signs and symptoms of UTI. This deficient practice placed Resident 1 at risk for infection from delayed treatment. Findings: During a review of Resident 1's Admission Record (AR), the AR indicated the facility admitted Resident 1 on 7/2/2021 and readmitted on [DATE], with diagnoses that included dementia (long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily functioning) and obstructive uropathy (a blockage of the urine flow in the tube [ureter] that carries urine between the kidneys and the bladder). During a review of Resident 1's Care Plan (CP) for the use of an indwelling catheter dated 1/16/2022, the CP indicated Resident 1 needed to be monitored every shift for signs and symptoms of UTI such as changes in urine color, blood in urine, abdominal pain and to notify the physician promptly. During a review of Resident 1's Physician Order Sheet (POS) dated 2/16/2024, the POS indicated the use of an indwelling foley catheter for obstructive uropathy for Resident 1. During an observation and concurrent interview on 5/21/2024 at 10 a.m., Resident 1 was sitting in a wheelchair in the activity room. Resident 1's indwelling catheter had large amount of cloudy urine output with an off-white-colored sediments in the drainage tubing. Resident 1 stated, I have no idea why I need this urine catheter. During an observation of Resident 1's indwelling catheter on 5/22/2024 at 3:48 p.m., with the presence of Licensed Vocational Nurse 4 (LVN 4) and Interim Director of Nursing (IDON), Resident 1's drainage tubing had large amount of cloudy urine output with an off-white-colored sediments. During an interview on 5/22/2024 at 4 p.m., LVN 4 stated he did not receive a report from the morning shift (7 a.m-3 p.m.) Charge Nurse regarding Resident 1's cloudy urine output with sediments until he was notified by the surveyor. LVN 4 stated Resident 1's catheter urine output was to be monitored for signs of urine infection and the physician should be immediately notified for appropriate treatment if indicated to prevent worsening of Resident 1's medical condition. LVN 4 stated there was no documented evidence Resident 1's physician was notified of Resident 1's cloudy urine output with sediments since 5/21/2024. (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's Policy and Procedures (P&P) titled, Urinary Tract Infections (Catheter-Associated), Guidelines for Preventing dated 6/2014, the P & P indicated nursing staff should observe the resident's urine output for signs and symptoms of UTI and report the signs and symptoms of UTI to the physician.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40037 Based on observation, interview and record review, the facility failed to follow physician's order to administer oxygen continuously to two of two sampled residents (Residents 15 and 58). These failures had the potential to result in the resident not receiving enough oxygen leading to a decline of health condition for Residents 15 and 58. Findings: a. During a review of Resident 15's Admission Record (AR), the AR indicated Resident 15 was readmitted to the facility on [DATE], with diagnoses that included dependence on supplemental oxygen, respiratory disorders (a type of disease that affects the lungs and other parts of the respiratory system) and chronic respiratory failure with hypoxia (low levels of oxygen in body tissues). During a review of Resident 15's Minimum Data Set (MDS, a resident assessment and care screening tool), dated 3/1/2024, the MDS indicated Resident 15 had clear speech, had the ability to understand and make self-understood. The MDS indicated Resident 15 had cognitive impairment (confusion or memory loss). Resident 15 required partial/moderate assistance (helper does less than half the effort, helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) for eating, toilet hygiene and transfer. During a review of Resident 15's Order Summary Report (OSR) dated 5/21/2024, the OSR indicated an order for Resident 15 dated 4/23/2024 to receive oxygen at 2 liters (L) per minute via nasal cannula (NC, tube to deliver oxygen) continuously. During an observation on 5/21/2024 at 9:27 am, Resident 15 was lying in bed with eyes closed. Resident 15 did not have the NC in his nostrils. One end of Resident 15's NC was connected to an oxygen tank and the tubing was coiled on the floor. Licensed Vocational Nurse 3 (LVN 3) picked up Resident 15's NC from the floor and placed it back into a plastic bag. During an interview on 5/21/2024 at 12:27 pm, LVN 3 stated Resident 15 had an order to receive continuous oxygen at 2L per minute. LVN 3 stated, it was important for Resident 15 to receive continuous oxygen because Resident 15 had respiratory disorder, and without enough oxygen in the body, Resident 15 could experience lethargy (a state of fatigue and low energy) and respiratory distress. During an interview with the Interim Director of Nursing (IDON) on 5/23/2024 at 2:50 pm, the IDON stated, it was important to follow the physician's order to administer continuous oxygen to Resident 15 all the time, either in bed or eating. The IDON stated, with low oxygen level, Resident 15 would have shortness of breath, altered mental status, and could result in hospitalization . 48905 (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. During a review of Resident 58's AR, the AR indicated Resident 58 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included hemiplegia (unable to move or control affected muscles) and hemiparesis (one-sided weakness) after cerebral infarction (disrupted blood flow to the brain), aphasia (full or partial loss of language abilities), and atelectasis (collapse of part or all of a lung). During a review of Resident 58's Order Summary Report (OSR) dated 2/6/2024, the OSR indicated Resident 58 had an order for Oxygen (O2) via NC at 2L per minute for shortness of breath (SOB) every shift. During a review of Resident 58's MDS dated [DATE], the MDS indicated Resident 58's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 58 had short-term and long-term memory problems. During an observation on 5/21/2024 at 10:05 AM in Resident 58's room, Resident 58's was observed lying in bed with eyes closed, with the NC on Resident 58's bedsheets and the O2 machine was running at 2L. During a concurrent observation and interview on 5/21/2024 at 10:12 AM with Licensed Vocational Nurse 1 (LVN 1) in Resident 58's room, Resident 58's NC was observed to remain lying on Resident 58's bedsheets. LVN 1 stated Resident 58's NC was not inserted in Resident 58's nostrils and needed to be on the resident as Resident 58 had a continuous order for O2 at 2L. LVN 1 stated, Resident 58 could go into respiratory distress or experience shortness of breath (SOB) if oxygen was not administered as ordered. During an interview on 5/23/2024 at 2:42 PM with the IDON, the IDON stated continuous O2 therapy was used if the resident had any respiratory issues such as SOB. The IDON stated it was a physician's order and if the order was not implemented, Resident 58 would experience respiratory distress. During a review of the facility's Policy and Procedure (P&P) titled, Oxygen Administration, revised 10/2010, the P&P indicated verify that there is a physician's order for this procedure. Review the physician's order or facility protocol for oxygen administration.		

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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. 40913 Based on observation, interview, and record review, the facility failed to reassess pain for one of one resident (Resident 40) after pain medication was administered. This deficient practice resulted in Resident 40 to continue to experience pain. Findings: During a review of Resident 40's Admission Record (AR), the AR indicated the facility admitted the resident on 6/3/2021 with diagnoses that included age-related osteoporosis (a condition that weakens the bones and increases the risk for fractures) and muscle wasting and atrophy (the thinning of muscle mass due to disuse or nerve problems) During a review of Resident 40's Minimum Data Set (MDS - a standardized assessment and care planning tool) dated 3/19/2024, the MDS indicated the resident had moderately impaired cognition (ability to understand) and required maximal assistance with rolling left and right, sit to lying, lying to sitting, sit to stand and transfers. During a concurrent observation and interview on 5/22/2024 at 11:03 am, Resident 40 was sitting in a wheelchair beside her bed. Resident 40 through a phone interpreter complained of pain to both knees and stated the pain was annoying. During an interview on 5/23/2024 at 9 am, Resident 40 through a phone interpreter stated she still had pain on the right knee at 8/10 pain level (0 =no pain and 10 = worst pain). During an interview on 5/23/2024 at 10:46 am, Licensed Vocational Nurse 2 (LVN 2) stated she applied diclofenac gel (medicine for pain that is applied on the skin) to Resident 40's left and right knee at 9 am. LVN 2 stated she did not go back to reassess Resident 40's pain because the resident would usually let LVN 2 know if she still had pain. During an interview on 5/23/2024 at 10:50 am, Resident 40 using an interpreter stated she had knee pain at 8/10. Resident 40 stated the licensed nurse did not come back to check if she still had pain after the nurse gave her pain medication. Resident 40 stated the pain was annoying. During an interview on 5/23/2024 at 10:56 am, LVN 2 stated she needed to reassess Resident 40's pain after giving pain medication so LVN 2 could manage the Resident 40's pain with both non-pharmacological interventions such as repositioning and by administering prn (as needed) pain medication. During a review of the facility's Policy and Procedure (P&P) titled Pain Assessment and Management revised 10/2022, the P&P indicated to monitor the following factors to determine if the resident's pain is being adequately controlled by monitoring the resident's response to interventions and level of comfort over time. The P&P indicated if pain has not been adequately controlled, the multidisciplinary team, including the physician, shall reconsider approaches and make adjustments as indicated.		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 14330 Based on observation, interview and record review, the facility failed to attempt the use of appropriate alternatives to bed rails before its installation for one of one sampled resident (Resident 59). This deficient practice placed Resident 59 at risk for entrapment and injury from the use of bed rails. Findings: During a review of Resident 59's Admission Record (AR), the AR indicated the facility admitted the resident on 12/24/2022 and readmitted Resident 59 on 2/29/2024, with diagnoses that included dementia (long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily functioning) and diabetes mellitus (a condition that happens when the blood sugar [glucose] is too high). During an observation and concurrent interview on 5/21/2024 at 9:50 a.m., Resident 59 was on left side lying position in a low bed with quarter length bed rails up on both sides. Resident 59 was alert and non-communicative. Resident 59 was able to move side to side in bed by herself without holding onto the bed rails. Certified Nursing Assistant 5 (CNA 5) stated he did not know why Resident 59 had bed rails. CNA 5 stated a female Charge Nurse (unidentified) told him to make sure Resident 59's bed rails were always up. During a concurrent interview and record review on 5/23/2024 at 3:45 p.m., with the Interim Director of Nursing (IDON), Resident 59's Bed Rail Observation/Assessment form dated 2/29/2024 was reviewed. Resident 59's Bed Rail Observation/Assessment form indicated the use of bed rails on both sides for bed mobility (moving from one bed position to another) per family's request. Resident 59's medical record did not have documented evidence that appropriate alternatives to bed rails were tried by the facility before the bed rails were used for Resident 59. The IDON stated the use of bed rails were an accident hazard for Resident 59 because it could cause serious injury and /or death due to entrapment of resident's head or limb (arm or leg) in between the gap of bed rails. During a review of the facility's Policy and Procedures (P & P) titled, Bed Safety and Bed Rails dated 8/2022, the P & P indicated appropriate alternatives to bed rails were to be attempted such as roll guards, foam bumpers, lowering the bed and concave mattress. The P & P also indicated if attempted alternatives do not adequately meet the resident's needs, the resident should be assessed for the risk of entrapment before the bed rails were to be used.		

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. 14330 Based on observation, interview, and record review, the facility failed to post accurate staffing information of actual hours worked by the licensed and unlicensed nursing staff directly responsible for resident care per shift daily for two of two days inspected (5/21/2024 and 5/22/2024). The staffing information included the actual worked hours of the Minimum Data Set (MDS) nurse that was not directly responsible for resident care. The staffing information did not indicate the name of the facility. This failure had the potential to affect resident care from inadequate staffing. Findings: During an observation on 5/21/2024 at 9 a.m. and 5/22/2024 at 8 a.m., the facility's staffing information was posted on the consumer board. The staffing information indicated actual hours worked by the nursing staff on all shifts (7 am-3 pm, 3 pm-11 pm and 11 pm-7 am) and the MDS nurse. The facility's name was not indicated in the staffing information. During a concurrent interview and record review on 5/24/2024 at 2:05 p.m. with the Director of Staff Development (DSD), the DSD stated the staffing information for 5/21/2024 and 5/22/2024 were projected worked hours of the nursing staff on all shifts. The DSD stated direct resident care is hands-on care provided to a resident such as feeding, giving medication, dressing and toileting. The DSD stated she thought MDS nurse was doing direct care when the MDS nurse does the resident assessment. The DSD stated accurate staffing information was important for the residents and visitors to know the facility had enough staff to provide the necessary care to the residents. During a review of the facility's Policy and Procedures (P & P) titled, Posting Direct Care Daily Staffing Numbers dated 8/2022, the P & P indicated staffing information should include the name of the facility, Charge Nurse or designee should compute the number of direct care staff and completes the nurse staffing information within two hours of the beginning of each shift. The P & P also indicated direct resident care means the staff was responsible for resident's total care such as giving medications, assisting with activities of daily living and nursing assessments.		

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 14330 Based on observation, interview, and record review, the facility failed to ensure one of five sampled residents (Resident 59) on psychotropic drugs (any drug that affects brain activities associated with mood, emotions, and behavior) was free from unnecessary medications by failing to ensure staff attempted a Gradual Dose Reduction ([GDR] the stepwise tapering of a dose to determine if symptoms, condition, or risks can be managed by a lower dose or if the dose or medication can be discontinued) of Resident 59 for the use of Quetiapine Fumarate ([antipsychotic drug] a drug use to treat symptoms of psychosis or disconnection from reality) 25 milligram ([mg] unit of measurement) since ordered on 2/29/2024. This deficient practice placed Resident 59 at risk for adverse drug reaction (a harmful and unintended response to a medicine). Findings: During a review of Resident 59's Admission Record (AR), the AR indicated the facility admitted the resident on 12/24/2022 and readmitted Resident 59 on 2/29/2024, with diagnoses that included dementia (long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily functioning) and diabetes mellitus (a condition that happens when the blood sugar [glucose] is too high). During a medication pass observation on 5/23/2024 at 9:07 a.m., Resident 59 was lying on her back in low bed with quarter length bed rails on both sides. Resident 59 was alert and non-communicative. Resident 59 was cooperative with staff and calm during the medication pass. During a review of Resident 59's Physician Order Sheet (POS) dated 2/29/2024, the POS indicated for licensed staff to administer Quetiapine Fumarate 25 mg one tablet by mouth three times a day for bipolar disorder for Resident 59, as manifested by striking out. During a review of Resident 59's Medication Administration Record (MAR) dated 5/1/2024 through 5/22/2024, the MAR indicated Resident 59 received Quetiapine Fumarate 25 mg one tablet by mouth every day, three times a day for striking out. The MAR also indicated Resident 59 had one episode of striking out in the past 22 days (5/1/2024 - 5/22/2024). (continued on next page)		

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 5/24/2024 at 10:31 p.m., with the Interim Director of Nursing (IDON), Resident 59's medical record was reviewed. Resident 59's medical record indicated Resident 59 was on Quetiapine Fumarate 50 mg once a day for striking out since 12/24/2022. Resident 59 was readmitted to the facility on [DATE], with the Physician Order for Quetiapine Fumarate 25 mg three times a day for striking out. The IDON stated Resident 59's Quetiapine Fumarate daily total dose was increased from 50 mg to 75 mg without an adequate indication. The MAR in February 2024 (2/1/2024 - 2/29/2024) indicated Resident 59 had one episode of striking out. The medical record of Resident 59 did not contain information of a past or recent failed attempt of GDR for Quetiapine Fumarate since 12/24/2022, to medically justify that GDR would be clinically contraindicated for Resident 59. The IDON stated GDR was necessary to determine if Resident 59's target behavior symptom of striking out could be managed by a lower dose to prevent an adverse drug reaction. During a review of the facility's Policy and Procedures (P&P) titled, Tapering Psychotropic Medications and Gradual Dose Reduction dated 3/2007, the P&P indicated a resident who was admitted on a psychotropic medication or after the resident has been started on a psychotropic medication, the staff and practitioner should attempt a GDR within the first year in two separate quarters (with at least one month between the attempts) unless clinically contraindicated. The P&P also indicated after the first year, the facility shall attempt GDR at least annually, unless clinically contraindicated.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 40037 Based on observation, interview and record review, the facility failed to ensure quaternary ammonium (chemical used as disinfectant) sanitizer solution used for cleaning the food preparation area and dishwasher chlorine had the required concentration for sanitizing for one of one facility kitchen. 1. The sanitizing solution the facility used was zero (0) parts per million (ppm, unit of measurement used to describe very small concentrations of a substance in a larger solution) and the recommended concentration for cleaning solution was 100 ppm. 2. The Low-Temperature Dishwashing Machine (wash and rinse cycles that run between 120- and 150-degrees Fahrenheit that require chemical sanitizers) chlorine level was 10 ppm and the recommended Low-Temperature Dishwashing Machine chlorine was 50-100 ppm. These failures had the potential to result in dishes and utensils not properly cleaned and food preparation areas were not sanitized that could result to food borne illnesses. Findings: During an inspection to the facility's kitchen on 5/21/2024 at 8:25 am, with the Registered Dietitian (RD), there were two red buckets with sanitizing solution and a cloth in each bucket. Both buckets' quaternary solution concentrations were tested with test strip and the results were 0 ppm for both buckets. There was one Low- Temperature Dishwashing Machine in the facility's kitchen. The test result for the low temperature dishwasher was 10 ppm for chlorine concentration. The RD stated, the facility used ammonium quaternary solution to clean food preparation surfaces. The RD stated, ammonium quaternary solution concentration needed to be between 200-400ppm to effectively disinfect food preparation surfaces. The RD stated it was important to have the required concentration in red buckets and dishwasher to disinfect the dishes and food preparation areas to prevent cross contamination and food borne illness. During an interview on 5/22/2024 at 11:48 am, with the facility's Dietary Supervisor (DS), the DS stated the facility used chemicals in red buckets and dishwasher for disinfecting food preparation areas and dishes. The DS stated the concentration of the chemicals needed to reach required concentration levels to effectively disinfect food preparation surfaces, dishes, and utensils to avoid infection. The DS stated residents would get sick if the dishes and food preparation areas were not sanitized. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's Policy and Procedure (P&P) titled Quaternary Ammonium Log Policy, dated 2023, the P&P indicated The concentration of the ammonium in the quaternary sanitizer will be tested to ensure the effectiveness of the solution. The quaternary solution, used for sanitizing clean work surfaces in the kitchen, will be made according to the instructions on the product container or dispensing device set up for the specific quat product. The food and nutrition services worker will place the solution in the appropriate bucket labeled for its contents and will test the concentration of the sanitation solution. The concentration will be tested at least every shift or when the solution is cloudy. The solution will be replaced when the reading is below 200 ppm. The replacement solution will be tested prior to usage. During a review of the facility's P&P titled Dishwashing, dated 2023, the P&P indicated All dishes will be properly sanitized through the dishwasher. Low-temperature machine: use the machine at a range of 120 F to 140 F. the chlorine should read 50-100 ppm on dish surface in final rinse. The proper chlorine level is crucial in sanitizing the dishes.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40037 Based on observation, interview and record review, the facility failed to implement infection control measures for two of six sampled residents (Residents 15 and 41) by failing to: a. Discard Resident 15's nasal cannula (NC, tubing to deliver oxygen) that was found on the floor. b. Follow its Policy and Procedure (P&P) for Enhanced Barrier Precautions (EBP- a resident-centered and activity-based approach for preventing multidrug resistant organism [MDRO]) when Certified Nursing Assistant 3 (CNA 3) did not wear the required Personal Protective Equipment (PPE - equipment worn to minimize exposure to illnesses) during linen change of Resident 41. These failures had the potential to result in cross contamination (the process by which bacteria is transferred from one surface or object to another) and infection. Findings: a. During a review of Resident 15's Admission Record (AR), the AR indicated Resident 15 was readmitted to the facility on [DATE], with diagnoses that included dependence on supplemental oxygen, respiratory disorders (a type of disease that affects the lungs and other parts of the respiratory system) and chronic respiratory failure with hypoxia (low levels of oxygen in body tissues). During a review of Resident 15's Minimum Data Set (MDS, a resident assessment and care screening tool), dated 3/1/2024, the MDS indicated Resident 15 had clear speech, had the ability to understand and make self-understood. The MDS indicated Resident 15 had cognitive impairment (confusion or memory loss). Resident 15 required partial/moderate assistance (helper does less than half the effort, helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) for eating, toilet hygiene and transfer. During an observation on 5/21/2024 at 9:27 am, Resident 15 was lying in bed with eyes closed. Resident 15 did not have the NC in his nostrils. One end of Resident 15's NC was connected to an oxygen tank and the tubing was coiled on the floor. Licensed Vocational Nurse 3 (LVN 3) picked up Resident 15's NC from the floor and placed it back into a plastic bag. During a concurrent interview LVN 3 stated, LVN 3 needed to discard Resident 15's NC that was on the floor and should not place it back into the bag because it was dirty. LVN 3 stated it was an infection control measure to not place the NC back in the bag. During an interview with Interim Director of Nursing (IDON) on 5/23/2024 at 2:50 pm, the IDON stated, if Resident 15's NC was touching the floor, staff should not place it back in the bag and the contaminated NC needed to be thrown away. The IDON stated, Resident 15 would get infected using a contaminated NC. During a review of the facility's Policy and Procedure (P&P) titled Department (Respiratory Therapy)-Prevention of Infection, revised 11/2011, the P&P indicated, The purpose of the P&P was to guide prevention of infection associated with respiratory therapy tasks and equipment, including ventilators, among residents and staff. Change the oxygen cannula and tubing every seven days, or as needed. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	40913 b. During a review of Resident 41's AR, the AR indicated the facility admitted the resident on 4/14/2020 and readmitted on [DATE] with diagnoses that included End Stage Renal Disease (ESRD - person's kidneys cease functioning on a permanent basis) and dependence on renal dialysis (treatment for kidney failure that removes toxins, waste products and excess fluids by filtering the blood). During a review of Resident 41's MDS dated [DATE], the MDS indicated the resident had intact cognition. The MDS indicated Resident 41 required maximal assistance (helper lifts or holds trunk or limbs and provides more than half the effort) for all activities of daily living except eating where the resident required set up. During a review of Resident 41's care plan for EBP initiated on 5/13/2024, the care plan indicated to utilize PPE (gown, gloves, face shield as indicated) during high-contact resident care activities (such as dressing, bathing/showering, transferring, hygiene, linen changes, brief changes, toileting assistance, device care and wound care.) During a concurrent observation and interview on 5/23/2024 at 8:40 am, CNA 3 removed the bed linens from Resident 41's bed. CNA 3 was not wearing an isolation gown. There was an EBP sign posted outside Resident 41's room. CNA 3 stated she thought EBP would only be implemented during close resident contact. CNA 3 read the posted EBP signage that included changing bed linens. During an interview on 5/24/2024 at 9:28 am with the facility's Infection Prevention Nurse (IPN- a nurse who helps prevent and identify the spread of infectious disease in the healthcare environment), the IPN stated EBP would be followed for residents with wounds, indwelling medical devices such as foley catheters and residents with dialysis access. During a review of Resident 41's recapped Physician Orders, with active orders as of 5/24/2024, the Physician Order indicated EBP during high contact resident care activities secondary to dependence on renal dialysis. During a review of the facility's P&P titled Isolation - Transmission-Based Precautions & Enhanced Barrier Precautions dated March 2024, the P&P indicated EBP are indicated for residents with any of the following: . wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with an MDRO. Wear gowns and gloves while performing the following high-contact tasks associated with the greatest risk for MDRO contamination of staff hands, clothes, and the environment such as: .changing bed linens.		

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 05/24/2024
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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40913 Based on observation, interview, and record review, the facility failed to ensure 16 of 32 resident rooms (Rooms 2, 3, 4, 5, 6, 8, 10, 11, 22, 24, 28, 29, 30, 31, 32 and 33) met the requirement of 80 square feet (sq. ft.) per resident in multiple resident bedrooms. This deficient practice had the potential to affect the care provided to the residents. Findings: During an observation on 5/23/2024 from 9:00 am to 5:00 pm, 16 resident rooms indicated on the room waiver request were observed, as follows: In room [ROOM NUMBER], there were 3 beds in the room, only bed A & B were occupied. In Rooms 3, 4, 5 and 6, there were 3 beds in the room, all beds were occupied. In room [ROOM NUMBER], there were 2 beds in the room, only bed B was occupied. In room [ROOM NUMBER], there were 2 beds in the room, all beds were occupied. In room [ROOM NUMBER], there were 3 beds in the room, all beds were occupied. In room [ROOM NUMBER], there were 3 beds in the room, Bed A was on bed hold and bed B & C were occupied. In room [ROOM NUMBER], there were 3 beds in the room, only beds B & C were occupied. In room [ROOM NUMBER], 29, 30 and 31, there were 4 beds in the room, all beds were occupied. In room [ROOM NUMBER], there were 3 beds in the room, all beds were occupied. In room [ROOM NUMBER], there were 4 beds in the room, all beds were occupied. During a team meeting conducted on 5/23/2024 at 2:00 pm, there was no complaint regarding the space in the rooms identified above. During an observation of the above rooms on 5/24/2024 at 3:15 pm, there was sufficient space for the residents and staff to move in and out of the room during delivery of care and there was enough space to store the resident's personal items. The residents in these rooms were able to move their wheelchairs while inside the room. There was enough space for the beds, dresser, closets, and other medical equipment. (continued on next page)		

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 05/24/2024
NAME OF PROVIDER OR SUPPLIER Valley View Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 3111 Santa Anita Ave El Monte, CA 91733	
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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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	During an interview on 5/24/2024 at 3:30 pm, the Operations Manager stated the facility had 16 resident rooms that did not meet the 80 square feet per resident requirement and will continue to request a waiver for the rooms. During a review of the room waiver letter request submitted by the facility, dated 5/24/2024, the room waiver letter request indicated the facility is requesting for a waiver of the room size per bed per room for the following rooms: Room Number Number of Beds Room Size (square feet) 2 3 214.5 3 3 214.5 4 3 214.5 5 3 214.5 6 3 218.5 8 2 154 10 3 218.4 11 3 218.4 22 3 214.5 24 3 214.5 28 4 288 29 4 288 30 4 288 31 4 288 32 4 288 33 4 288		