

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055443	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2025
NAME OF PROVIDER OR SUPPLIER West Valley Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 7057 Shoup Ave West Hills, CA 91307	

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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>Based on observation, interview and record review, the facility failed to provide reasonable accommodation of resident needs and preferences by failing to ensure the call light (an alerting device for nurses or other nursing personnel to assist a resident when in need) was within reach for one of five sampled residents (Resident 3).</p> <p>This deficient practice had the potential to result in a delay of care and services and possible injury to residents when unable to obtain the needed care and services.</p> <p>Findings:</p> <p>During a review of Resident 3's admission Record, the admission Record indicated the facility originally admitted Resident 3 on 7/7/2022 and re-admitted Resident 3 on 6/15/2024 with diagnoses including intervertebral disc degeneration (breakdown of one or more discs that separate the bones of the spine), muscle wasting and atrophy (refers to the loss of muscle mass and strength), limitation of activities due to disability, and adult failure to thrive (a syndrome of decline in older adults, characterized by weight loss, decreased appetite, inactivity, and a decline in the ability to perform daily activities).</p> <p>During a review of Resident 3's Minimum Data Set (MDS - a resident assessment tool) dated 5/20/2025, the MDS indicated Resident 3's cognitive (the mental process involved in knowing, learning, and understanding things) skills for daily decision making was severely impaired. The MDS indicated Resident 3 was dependent on staff with eating, oral hygiene, toileting hygiene, showering or bathing, dressing, personal hygiene and mobility (movement).</p> <p>During an observation on 6/24/2025 at 11:27 a.m., in Resident 3's room, observed Resident 3 in bed, with the call light not within reach. Observed Resident 3's call light tucked in between Resident 3's mattress and pillow.</p> <p>During a concurrent observation and interview on 6/24/2025 at 11:30 a.m., with Licensed Vocation Nurse 1 (LVN 1), in Resident 3's room, observed Resident 3 in bed with the call light not within reach. Observed Resident 3's call light tucked in between Resident 3's mattress and pillow. Observed LVN 1 place the call light within Resident 3' s reach and stated Resident 3' s call light was not within reach. LVN 1 continued to state that the call light should always be next to the resident for safety.</p> <p>(continued on next page)</p>

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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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's policy and procedure (P&P) titled, Accommodation of Needs, last reviewed on 5/28/2025, the P&P indicated the facility's environment and staff behaviors are directed toward assisting the resident in maintaining and/or achieving safe independent functioning, dignity and well-being. In order to accommodate individual needs and preference, staff attitudes and behaviors are directed towards assisting the residents in maintaining independence, dignity and well-being to the extent possible and in accordance with the residents' wishes, for example, interacting with residents in ways that accommodate the physical or sensory limitations of the resident, promote communication and maintain dignity.</p> <p>During a review of the facility's P&P titled, Answering the Call Light, last reviewed on 5/28/2025, the P&P indicated to ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>Based on interview and record review, the facility failed to implement its policy and procedure (P&P) on care planning- interdisciplinary (a group of professionals from different fields who work together to achieve a shared goal for the resident) team by failing to ensure the required interdisciplinary team members, including a physician, a registered nurse (RN), and a certified nurse assistant (CNA), were in attendance during a scheduled care plan meeting for one of five sampled residents (Resident 1).</p> <p>This deficient practice had the potential to affect residents' care coordination, potentially leading to unmet needs and avoidable declines in condition.</p> <p>Findings:</p> <p>During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 5/19/2025 with diagnoses including generalized arthritis (swelling and tenderness in one or more joints, causing joint pain or stiffness that often gets worse with age), syncope (a sudden temporary loss of consciousness, commonly known as fainting or passing out) and collapse (fall down), type two (2) diabetes mellitus (high levels of sugar in the blood) and depression (a mood disorder characterized by persistent feelings of sadness, loss of interest, and a range of other emotional and physical symptoms that significantly interfere with daily life).</p> <p>During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 5/22/2025, the MDS indicated Resident 1 had moderate cognitive (the mental process involved in knowing, learning, and understanding things) impairment. The MDS indicated Resident 1 required partial/moderate assistance from staff with eating and required substantial/maximal assistance from staff with oral hygiene, showering/bathing, personal hygiene and mobility (movement).</p> <p>During a review of Resident 1's IDT Conference Notes dated 6/3/2025, timed at 12:27 p.m., the IDT Conference Notes indicated a list of IDT members who attended the IDT meeting/conference. The list included the following:</p> <ul style="list-style-type: none"> - Resident 1's POA - MDS Nurse (MDSN) - Occupational Therapist 1 (OT 1) - Social Services Staff 1 (SSS 1) <p>(continued on next page)</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-</p> <p>Dietary Services Supervisor (DSS)</p> <p>During an interview on 6/23/2025 at 4:35 p.m., with Resident 1's Power of Attorney (POA- legal authorization for a designated person to make decisions about the resident's medical care or finances), Resident 1's POA stated that an IDT meeting was conducted on 6/3/2025; however, neither a physician nor an RN was present to address Resident 1's POA's questions regarding the resident's medical condition and the plan of care.</p> <p>During an interview on 6/25/2025 at 10:00 a.m., with the Social Services Director (SSD), the SSD stated that an admission IDT meeting is conducted within seven (7) days of admission and annually thereafter. The SSD stated that the IDT meetings are attended by the MDS nurse, a staff from social services department, the resident and/or their responsible party, and a staff from the rehabilitation department. The SSD continued to state that physicians, RNs, and CNAs do not join and participate in the IDT meeting. The SSD stated that all attendees are documented on the IDT Conference Note.</p> <p>During a concurrent interview and record review on 6/25/2025 at 11:30 a.m., with the Assistant Director of Nursing (ADON), Resident 1's IDT Conference Notes dated 6/3/25 and the facility's P&P titled, Care Planning- Interdisciplinary Team were reviewed. The ADON stated that attendees of the IDT meetings include the MDS nurse or case manager, a representative from the rehabilitation department, social services department and activities department. The ADON stated that the MDS Nurse who attended the IDT meeting on 6/3/2025 was a licensed vocational nurse (LVN), and not an RN. The ADON further stated that Resident 1's attending physician, the RN responsible for Resident 1's care, and the assigned CNA responsible for Resident 1 were not present at the IDT meeting held on 6/3/2025.</p> <p>During a concurrent interview and record review on 6/25/2025 at 12:00 p.m., with the Administrator (ADM), the facility's P&P titled Care Planning- Interdisciplinary Team dated 5/28/25 was reviewed. The ADM stated that she is responsible for the overall operations of the facility and provides supervision for all departments. The ADM stated that based on the facility's P&P, an IDT meeting should include the attendance of the physician, an RN, a CNA, a representative from dietary, and the resident and/or responsible party. The ADM stated that it is important for a physician to be part of the IDT meeting to be able to answer questions that the resident and/or responsible party may have regarding the care of the resident and/or extend explanations of medication information that the RN is unable to explain. The ADM continued to state that an RN should attend IDT meetings to be able to discuss the overall care and clinical progress of the resident, and CNA to provide input on the resident's daily routine and activities of daily living (ADLs - refers to the basic tasks that individuals perform to maintain their daily lives and care for themselves such as toileting, eating and personal hygiene). The ADM further stated that it is essential for all disciplines to meet with the resident and/or responsible party to ensure that the resident's needs are fully understood and met, questions are answered, and all parties remain on the same page to prevent miscommunication.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's P&P titled, Care Planning- Interdisciplinary Team, last reviewed on 5/28/2025, the P&P indicated the interdisciplinary team is responsible for the development of resident care plans. The IDT includes but not is not limited to: a. the resident's attending physician; b. a registered nurse with responsibility for the resident; c. a nursing assistant with the responsibility for the resident; d. a member of the food and nutrition service staff; e. to the extent practicable, the resident and/or the resident's representative; and f. other staff as appropriate or necessary to meet the needs of the resident, or as requested by the resident.</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on interview and record review, the facility failed to provide the needed care and services that were resident-centered for one of five sampled residents (Resident 4) by the facility failing to accurately transcribe Resident 4's Lenalidomide (a medication used to treat multiple myeloma [a type of blood cancer that originates in plasma cells - a type of white blood cells that produce antibodies {a protein produced by the immune system to identify and neutralize foreign substances like bacteria and viruses}]) order.</p> <p>This deficient practice resulted in Resident 4 not receiving Resident 4's prescribed medication as ordered and placed Resident 4 at risk for worsening medical condition and compromised immune system that may lead to infection.</p> <p>Findings:</p> <p>During a review of Resident 4's admission Record, the admission Record indicated the facility originally admitted Resident 4 on 5/15/2025 and re-admitted Resident 4 on 6/23/2025 with diagnoses including malignant neoplasm of bone (bone cancer) and multiple myeloma not having achieved remission (period where the signs and symptoms of a disease, such as cancer, decrease or disappear).</p> <p>During a review of Resident 4's Minimum Data Set (MDS - a resident assessment tool) dated 5/19/2025, the MDS indicated Resident 4 had moderate cognitive impairment (problems with a person's ability to think, learn, remember, use judgement, and make decisions). The MDS indicated that Resident 4 required partial/moderate assistance from staff with eating, substantial/maximal assistance from staff with oral hygiene, showering or bathing, personal hygiene, and is dependent on staff with toileting hygiene and lower body dressing.</p> <p>During a review of Resident 4's General Acute Care Hospital (GACH) Discharge Instructions dated 5/15/2025, the GACH Discharge Instructions indicated to continue Lenalidomide 20 milligrams (mg- unit of measurement) one capsule by mouth once daily for the first 21 days of each 28-day cycle. Next dose: 5/16/2025 at 9:00 a.m.</p> <p>During a review of Resident 4's Physician's Order dated 5/15/2025 at 7:53 p.m., the Physician's Order indicated to give Lenalidomide one capsule by mouth one time a day every 21 day(s) for multiple myeloma not having achieved remission. Family will supply the medication.</p> <p>During a review of Resident 4's Medication Administration Record (MAR - a report detailing the medications administered to a resident) from 5/16/2025 to 5/31/2025, the MAR indicated Lenalidomide 20 mg was only administered once, on 5/22/2025. The MAR for Lenalidomide 20 mg indicated that for all other dates between 5/16/2025 to 5/31/2025, excluding 5/22/2025, the MAR was marked with an X, indicating the medication was not administered.</p> <p>During a review of Resident 4's care plan (untitled) with an initiated date of 5/15/2025, the care plan indicated potential for side effects (any unintended or unexpected effects that occur as a result of taking a medication), complications, or adverse reactions (refers to unintended and undesirable responses to a medication) related to ordered use of a drug: Lenalidomide Oral Capsule 20 mg. The care plan interventions included to administer the medication as ordered.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 4's Change in Condition (COC- when there is a sudden change in a resident's condition) Evaluation form dated 6/5/2025, timed at 3:28 p.m., the COC indicated a medication error in transcribing Lenalidomide oral capsule 20 mg. The COC indicated Lenalidomide oral capsule 20 mg medication was incorrectly transcribed to every 21 days instead of daily for 21 days on and seven (7) days off (28-day cycle).</p> <p>During an interview on 6/26/2025 at 1:15 p.m., with the Director of Nursing (DON), the DON stated the desk nurse who carried out Resident 4's admission orders misunderstood the order. The DON stated that instead of transcribing Lenalidomide oral capsule 20 mg daily for 21 days, the desk nurse transcribed Lenalidomide oral capsule 20 mg every 21 days. The DON stated that she (DON) was made aware of the medication error when it was brought to the DON's attention by Resident 4's daughter. The DON stated that Resident 4's daughter comes to the facility to bring a refill of the medication (Lenalidomide). The DON stated that during the visit, Resident 4's daughter questioned the DON about the number of capsules remaining in the previous bottle and asked why it still hasn't been finished. The DON stated that the DON does not know how this incident happened. The DON further stated that the desk nurse who incorrectly transcribed Resident 4's Lenalidomide order was terminated.</p> <p>During a follow-up interview on 6/26/2025 at 4:05 p.m., with the DON, the DON stated that the facility failed to double check Resident 4's GACH Discharge Instructions to ensure the accuracy of the medication order transcribed. The DON stated that the facility's registered nurse (RN) supervisor on duty in the morning was responsible for checking and verifying the accuracy of the admission orders from the previous night. The DON continued to state that the RN supervisor on duty on 5/16/2025 should have verified the admission orders transcribed by the desk nurse on 5/15/2025.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Medication Order, last reviewed on 5/28/2025, the P&P indicated the purpose of this procedure is to establish uniform guidelines in the receiving and recording of medication orders. Under Recording Orders: When recording orders for medication, specify the type, route, dosage, frequency and strength of the medication ordered.</p> <p>During a review of the facility's P&P titled, Administering Medications, last reviewed on 5/28/2025, the P&P indicated medications are administered in a safe and timely manner and as prescribed.</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility to ensure two of five sampled residents (Resident 1 and Resident 2) received care and services in accordance with professional standards of practice by:</p> <ol style="list-style-type: none"> 1. Failing to administer Resident 1's acetaminophen (a medication used to relieve mild to moderate pain) as prescribed by the physician. <p>This deficient practice had the potential for Resident 1 to experience untreated pain.</p> <ol style="list-style-type: none"> 2. Failing to ensure licensed nurses attempted and documented nonpharmacological interventions (treatments or strategies that do not involve the use of medications) prior to administering as needed (PRN) hydrocodone-acetaminophen (medication used to treat severe pain) to Resident 2. <p>This deficient practice had the potential to place the resident at an increased risk of experiencing adverse side effects (undesired harmful effect resulting from a medication or other intervention).</p> <p>Findings:</p> <ol style="list-style-type: none"> a. During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 5/19/2025 with diagnoses that included primary generalized arthritis (swelling and tenderness in one or more joints, causing joint pain or stiffness that often gets worse with age), syncope (fainting) and collapse (fall down), and other chest pain. <p>During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 5/22/2025, the MDS indicated Resident 1 had moderate cognitive (the process of acquiring knowledge and understanding through thought, experience, and senses) impairment. The MDS further indicated that Resident 1 required partial/moderate assistance with eating, substantial/maximal assistance with oral hygiene and personal hygiene, and was dependent on staff with toileting.</p> <p>During a review of Resident 1's Order Summary Report, the Order Summary Report indicated an order for acetaminophen tablet 325 milligrams (mg- unit of measurement), give two (2) tablets by mouth every four (4) hours as needed for mild pain (1-3 scale- numerical scale used to measure pain with 0 being no pain and 10 being the worst pain)].</p> <p>During a concurrent interview and record review on 6/24/2025 at 2:30 p.m., with the Assistant Director of Nursing (ADON), reviewed Resident 1's Medication Administration Record (MAR- a report detailing the medications administered to a resident) for 5/2025. The ADON stated that pain medication is administered to residents per physician's order and per resident's pain scale assessment. The ADON stated that on 5/21/2025 and 5/24/2025, Resident 1 was administered acetaminophen 325 mg two (2) tablets for pain scale of four (4) out of 10. The ADON stated that Resident 1 should not have been given acetaminophen for a pain scale level of four (4) because the order indicated to administer acetaminophen for pain scale of three (3) out of 10. The ADON further stated the charge nurse should have called Resident 1's physician for another pain medication order that would be appropriate for Resident 1's pain scale level. The ADON stated the physician should have been called and informed so that Resident 1 would have received the appropriate pain medication to address and relieve the pain.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility's policy and procedure (P&P) titled, Pain Assessment and Management, review date 5/28/2025, the policy indicated the pain management program is based on a facility wide commitment to appropriate assessment and treatment of pain, based on professional standards of practice, the comprehensive care plan, and the resident's choices related to pain management.</p> <p>During a review of the facility's P&P titled, Administering Medications, review date 5/28/2025, the policy indicated medications are administered in a safe and timely manner, and as prescribed. Medications are administered in accordance with prescriber orders. If a dosage is believed to be inappropriate or excessive for a resident . the person preparing or administering the medication will contact the prescriber, the resident's attending physician or the facility's medical director to discuss concerns.</p> <p>b. During a review of Resident 2's admission Record, the admission Record indicated the facility admitted Resident 2 on 4/24/2025 with diagnoses that included Parkinson's disease (a movement disorder of the nervous system that worsens over time) without dyskinesia (uncontrolled, involuntary muscle movement), other encephalopathy (a broad term for any brain disease that alters brain function or structure), and other low back pain.</p> <p>During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2 had moderate cognitive impairment. The MDS further indicated that Resident 2 required partial/moderate assistance with eating, substantial/maximal assistance with oral hygiene and personal hygiene, and is dependent on staff with toileting.</p> <p>During a review of Resident 2's Order Summary Report, the Order Summary Report indicated an order for hydrocodone-acetaminophen oral tablet 5-325 mg, give two (2) tablets by mouth every eight (8) hours as needed for severe pain (7-10 scale).</p> <p>During a review of Resident 2's care plan (a document that summarizes a resident's needs, goals, and care/treatment) dated 4/25/2025, the care plan indicated Resident 2 has pain and included an intervention for non-medication intervention such as: repositioning, distraction, music etc.</p> <p>During a concurrent interview and record review on 6/24/2025 at 3:00 p.m., with the ADON, reviewed Resident 2's MAR for 6/2025. The ADON stated that prior to administering pain medications, licensed nurses should be providing non-pharmacological interventions first. The ADON stated that Resident 2 was given hydrocodone-acetaminophen oral tablet 5-325 mg as needed for pain on 6/11/2025, 6/13/2025, 6/14/2025, 6/15/2025, 6/17/2025, 6/18/2025, 6/19/2025, 6/20/2025, 6/21/2025, 6/22/2025, 6/23/2025, and 6/24/2025. The ADON further reviewed Resident 2's MAR and stated licensed nurses did not document any attempted nonpharmacological interventions prior to administering hydrocodone-acetaminophen oral tablet 5-325 mg as needed for pain on the dates listed. The ADON stated that nonpharmacological interventions should be implemented first prior to the administration of narcotic medications to avoid unnecessary medications and for resident safety.</p> <p>During a review of the facility's P&P titled, Pain Assessment and Management, review date 5/28/2025, the policy indicated under implementing pain management strategies: non-pharmacological interventions may be appropriate alone or in conjunction with medications.</p>		

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<p>F 0711</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident's attending physician documented and completed a resident's History and Physical (H&P- a formal assessment by a healthcare provider that involves a resident interview, physical exam, and documentation of findings) within 72 hours following a resident's admission for two of three sampled residents (Resident 1 and Resident 2).</p> <p>This deficient practice had the potential for inconsistent care coordination due to incomplete medical records for Resident 1 and Resident 2.</p> <p>Findings:</p> <p>a. During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 5/19/2025 with diagnoses that included primary generalized arthritis (swelling and tenderness in one or more joints, causing joint pain or stiffness that often gets worse with age), syncope (fainting) and collapse (fall down), and other chest pain.</p> <p>During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 5/22/2025, the MDS indicated Resident 1 had moderate cognitive (the process of acquiring knowledge and understanding through thought, experience, and the senses) impairment. The MDS further indicated that Resident 1 required partial/moderate assistance with eating, substantial/maximal assistance with oral hygiene and personal hygiene, and was dependent on staff with toileting.</p> <p>During a concurrent interview and record review on 6/25/2025 at 12:23 p.m., with the Medical Records Director (MRD), reviewed Resident 1's admission Record. The MRD stated that all H&Ps are to be completed and signed within 72 hours of a resident's admission to the facility. The MRD reviewed Resident 1's admission Record and stated that Resident 1 was admitted on [DATE]. The MRD reviewed Resident 1's H&P and stated that Resident 1's H&P was documented on 5/27/2025. The MRD stated that Resident 1's H&P should have been completed within 72 hours of admission and should have been completed by 5/22/2025. Resident 1's H&P was completed seven (7) days after admission.</p> <p>b. During a review of Resident 2's admission Record, the admission Record indicated the facility admitted Resident 2 on 4/24/2025 with diagnoses that included Parkinson's disease (a movement disorder of the nervous system that worsens over time) without dyskinesia (uncontrolled, involuntary muscle movement), other encephalopathy (a broad term for any brain disease that alters brain function or structure), and other low back pain.</p> <p>During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2 had moderate cognitive impairment. The MDS further indicated that Resident 2 required partial/moderate assistance with eating, substantial/maximal assistance with oral hygiene and personal hygiene, and is dependent on staff with toileting.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055443	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2025
NAME OF PROVIDER OR SUPPLIER West Valley Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 7057 Shoup Ave West Hills, CA 91307	

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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<p>F 0711</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 6/25/2025 at 12:38 p.m., with the MRD, Resident 2's admission Record and H&P were reviewed. The MRD stated Resident 2 was admitted on [DATE]. The MRD reviewed Resident 2's H&P dated as a late entry for 4/26/2025 at 12:29 p.m. The MRD stated that Resident 2's H&P was documented as a late entry for 4/26/2025 and was created and signed on 5/5/2025 at 9:35 p.m. , nine (9) days after admission. The MRD stated that Resident 2's H&P should have been completed and signed by 4/29/2025.</p> <p>During an interview on 6/25/2025 at 12:40 p.m., with the Assistant Director of Nursing (ADON), the ADON stated that an admission H&P is important because it is a baseline assessment by the facility's physician, and it is a document where the physician will document their plan of care.</p> <p>During a review of the facility' policy and procedure (P&P) titled, History and Physical, review date 5/28/2025, the policy indicated the purpose of this policy is to ensure all residents admitted to the facility have a complete and current medical history and physical (H&P) examination on file in compliance with federal and California state requirements and to ensure that every resident has a documented history and physical (H&P) examination conducted and signed by a licensed physician nurse practitioner or physician assistant. The P&P further indicates a completed and signed H&P must be present in the resident's medical record within 72 hours after admission to the facility. The attending physician or designee (e.g. nurse practitioner or physician assistant) is responsible for completing, signing, and dating the H&P. The Director of Nursing (DON) or designee shall routinely audit new admission charts to ensure timely completion of the H&P. Non-compliance will be addressed immediately with the attending physician and/or medical director.</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>Based on interview and record review, the facility failed to ensure one of five sampled residents (Resident 4) was free from significant medication error by failing to ensure Resident 4's Lenalidomide (a medication used to treat multiple myeloma [a type of blood cancer that originates in plasma cells - a type of white blood cells that produce antibodies {a protein produced by the immune system to identify and neutralize foreign substances like bacteria and viruses}]) was administered as ordered.</p> <p>This deficient practice resulted in Resident 4 receiving one dose of a 21-day cycle medication.</p> <p>Findings:</p> <p>During a review of Resident 4's admission Record, the admission Record indicated the facility originally admitted Resident 4 on 5/15/2025 and re-admitted Resident 4 on 6/23/2025 with diagnoses including malignant neoplasm of bone (bone cancer) and multiple myeloma not having achieved remission (period where the signs and symptoms of a disease, such as cancer, decrease or disappear).</p> <p>During a review of Resident 4's Minimum Data Set (MDS - a resident assessment tool) dated 5/19/2025, the MDS indicated Resident 4 had moderate cognitive impairment (problems with a person's ability to think, learn, remember, use judgement, and make decisions). The MDS indicated that Resident 4 required partial/moderate assistance from staff with eating, substantial/maximal assistance from staff with oral hygiene, showering or bathing, personal hygiene, and is dependent on staff with toileting hygiene and lower body dressing.</p> <p>During a review of Resident 4's General Acute Care Hospital (GACH) Discharge Instructions dated 5/15/2025, the GACH Discharge Instructions indicated to continue Lenalidomide 20 milligrams (mg- unit of measurement) one capsule by mouth once daily for the first 21 days of each 28-day cycle. Next dose: 5/16/2025 at 9:00 a.m.</p> <p>During a review of Resident 4's Physician's Order dated 5/15/2025 at 7:53 p.m., the Physician's Order indicated to give Lenalidomide one capsule by mouth one time a day every 21 day(s) for multiple myeloma not having achieved remission. Family will supply the medication.</p> <p>During a review of Resident 4's Medication Administration Record (MAR - a report detailing the medications administered to a resident) from 5/16/2025 to 5/31/2025, the MAR indicated Lenalidomide 20 mg was only administered once, on 5/22/2025. The MAR for Lenalidomide 20 mg indicated that for all other dates between 5/16/2025 to 5/31/2025, excluding 5/22/2025, the MAR was marked with an X, indicating the medication was not administered.</p> <p>During a review of Resident 4's care plan (untitled) with an initiated date of 5/15/2025, the care plan indicated potential for side effects (any unintended or unexpected effects that occur as a result of taking a medication), complications, or adverse reactions (refers to unintended and undesirable responses to a medication) related to ordered use of a drug: Lenalidomide Oral Capsule 20 mg. The care plan interventions included to administer the medication as ordered.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 4's Change in Condition (COC- when there is a sudden change in a resident's condition) Evaluation form dated 6/5/2025, timed at 3:28 p.m., the COC indicated a medication error in transcribing Lenalidomide oral capsule 20 mg. The COC indicated Lenalidomide oral capsule 20 mg medication was incorrectly transcribed to every 21 days instead of daily for 21 days on and seven (7) days off (28-day cycle).</p> <p>During an interview on 6/26/2025 at 1:15 p.m., with the Director of Nursing (DON), the DON stated the desk nurse who carried out Resident 4's admission orders misunderstood the order. The DON stated that instead of transcribing Lenalidomide oral capsule 20 mg daily for 21 days, the desk nurse transcribed Lenalidomide oral capsule 20 mg every 21 days. The DON stated that she (DON) was made aware of the medication error when it was brought to the DON's attention by Resident 4's daughter. The DON stated that Resident 4's daughter comes to the facility to bring a refill of the medication (Lenalidomide). The DON stated that during the visit, Resident 4's daughter questioned the DON about the number of capsules remaining in the previous bottle and asked why it still hasn't been finished. The DON stated that the DON does not know how this incident happened. The DON further stated that the desk nurse who incorrectly transcribed Resident 4's Lenalidomide order was terminated.</p> <p>During a follow-up interview on 6/26/2025 at 4:05 p.m., with the DON, the DON stated that the facility failed to double check Resident 4's GACH Discharge Instructions to ensure the accuracy of the medication order transcribed. The DON stated that the facility's registered nurse (RN) supervisor on duty in the morning was responsible for checking and verifying the accuracy of the admission orders from the previous night. The DON continued to state that the RN supervisor on duty on 5/16/2025 should have verified the admission orders transcribed by the desk nurse on 5/15/2025.</p> <p>During a review of the facility's P&P titled, Administering Medications, last reviewed on 5/28/2025, the P&P indicated medications are administered in a safe and timely manner and as prescribed. The director of nursing services supervises and directs all personnel who administer medications and/or have related functions. Medications are administered in accordance with the prescriber's orders, including any required time frame.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Medication Order, last reviewed on 5/28/2025, the P&P indicated the purpose of this procedure is to establish uniform guidelines in the receiving and recording of medication orders. Under Recording Orders: When recording orders for medication, specify the type, route, dosage, frequency and strength of the medication ordered.</p>		