STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055443	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Valley Post Acute	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)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect the resident's right to be free from physical abuse for two of two sampled Residents (Resident 1 and Resident 2) when on 10/30/2025, Resident 1 hit Resident 2 in the face using a right closed fist and Resident 2 hit Resident 1's face with the wheelchair footrest.The facility failed to:1. Ensure the facility's policy and procedure (P&P) titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program, reviewed 5/28/2025, was followed which indicated residents have the right to be free from abuse.The resident abuse, neglect, and exploitation prevention program consists of a facility-wide commitment. to protect residents from abuse, neglect, exploitation or misappropriation of property, anyone including, but not necessarily limited to other residents and any other individuals. 2. Ensure there were interventions in place to prevent the physical altercation between Resident 2 and Resident 1 from occurring based on Resident 2's history of not liking noises and roommate incompatibilityThese deficient practices resulted in Resident 1 and Resident 2 being subjected to physical abuse while under the care of the facility. Resident 1 sustained scratches (thin, line-like cut, superficial break in the skin) on the bridge of the nose, the right side of nose, and the right thumb that needed first aid (initial assistance and care given to a resident who has been injured). Resident 2 sustained a cut (break or opening in the skin) at the bottom lip and reported pain on the right side of the face, head and left hand.Findings:During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 10/23/2025 with diagnoses including muscle wasting and atrophy (wasting or shrinking of a body part, tissue or organ), limitation of activities due to disability, other abnormalities of gait (a person's manner of walking) and mobility, and schizophrenia (a mental illness that is characterized by disturbances in thought).During a review of Resident 1's History and Physical (H&P) dated 10/24/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions.During a review of Resident 1's Minimum Data Set (MDS - a comprehensive assessment and screening tool) dated 10/27/2025, the MDS indicated Resident 1's cognition (conscious mental activities, and includes thinking, reasoning, understanding, learning, and remembering) was moderately impaired. The MDS indicated that Resident 1 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes the activity) with eating, and required substantial/maximal (helper does more than half the effort to complete the activity or the assistance of two or more helpers is required for the resident to complete the activity) assistance from staff with oral hygiene and personal hygiene.During a review of Resident 1's Change in Condition (COC- a significant change in resident's health status) Evaluation, dated 10/30/2025, timed at 8:45 p.m., documented by Licensed Vocational Nurse 1 (LVN 1), the COC Evaluation indicated Resident 2, who was Resident 1's roommate, Resident 2, was standing next to Resident 1 while Resident 1 was sitting on his bed. LVN 1 observed Resident 2 attacking Resident 1 with a wheelchair footrest.During a review of Resident 1's Nursing Note dated 10/30/2025, timed at 8:45 p.m., the Nursing Note indicated Resident 1 reported Resident 2 swung Resident 2's wheelchair footrest and hit Resident 1 in the face. The Nursing Note indicated Registered Nurse 1 (RN 1) assessed Resident 1. Resident 1 was observed with scratches measuring approximately 1.5 centimeters (cm- unit of measurement) on the bridge of nose, 0.5 cm on the right side of the nose and approximately .5 cm. on the right thumb. The Nursing Note indicated RN 1 provided first aid treatment to Resident 1.During a review of Resident 2's admission Record, the admission Record indicated the facility initially admitted Resident 2 on 6/27/2021 and readmitted Resident 2 on 10/16/2024 with diagnoses including unspecified dementia (a progressive state of decline in mental abilities), unspecified severity, with psychotic disturbance (a mental health state characterized by a loss of contact with reality, leading to hallucinations [seeing or hearing things that are not there] and delusions [firmly held false beliefs]) and unspecified psychosis (a severe mental condition in which thought and emotions are so affected that contact is lost with external reality) not due to a substance or unknown physiological condition.During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2's cognition was severely impaired. The MDS indicated Resident 2 had clear speech, usually had the ability to make self-understood, and usually had the ability to understand others. The MDS indicated Resident 2 required setup or clean-up assistance (helper sets up or cleans up; resident completes activity and helper assists only prior to or following the activity) with eating, supervision or touching assistance with oral hygiene, and required substantial/maximal assistance from staff with toileting and personal hygiene During a review of Resident 2's COC Evaluation

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop a comprehensive person-centered care plan (a written course of action that helps a resident achieve outcomes that improve their quality of life) for one of two sampled residents (Resident 2), who was identified to have behavioral triggers (something that causes the brain to react in a certain way, leading to a behavior). This deficient practice had the potential to result in the resident's behavioral needs not being properly addressed. Cross reference F600.Findings:During a review of Resident 2's admission Record, the admission Record indicated the facility readmitted Resident 2 on 10/16/2024 with diagnoses including unspecified dementia (a progressive state of decline in mental abilities), unspecified severity, with psychotic disturbance (a mental health state characterized by a loss of contact with reality, leading to hallucinations [seeing or hearing things that aren't there] and delusions [firmly held false beliefs])and unspecified psychosis (a severe mental condition in which thought and emotions are so affected that contact is lost with external reality) not due to a substance or unknown physiological condition.During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2's cognition was severely impaired. The MDS indicated Resident 2 had clear speech, usually had the ability to make self-understood, and usually had the ability to understand others. The MDS indicated Resident 2 required setup or clean-up assistance (helper sets up or cleans up; resident completes activity and helper assists only prior to or following the activity) with eating, supervision or touching assistance with oral hygiene, and required substantial/maximal assistance from staff with toileting and personal hygiene.During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 10/23/2025 with diagnoses including muscle wasting and atrophy (wasting or shrinking of a body part, tissue or organ), limitation of activities due to disability, other abnormalities of gait (a person's manner of walking) and mobility, and schizophrenia (a mental illness that is characterized by disturbances in thought).During a review of Resident 1's Minimum Data Set (MDS - a comprehensive assessment and screening tool) dated 10/27/2025, the MDS indicated Resident 1's cognition (conscious mental activities, and includes thinking, reasoning, understanding, learning, and remembering) was moderately impaired. The MDS indicated that Resident 1 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes the activity) with eating, and required substantial/maximal (helper does more than half the effort to complete the activity or the assistance of two or more helpers is required for the resident to complete the activity) assistance from staff with oral hygiene and personal hygiene.During a review of Resident 2's COC Evaluation, dated 10/30/2025, timed at 8:45 p.m., documented by LVN 1, the COC Evaluation indicated LVN 1 observed Resident 2 standing and hitting Resident 1 in the face with Resident 2's wheelchair footrest. The COC Evaluation indicated Resident 1 and Resident 2 were separated and upon assessment Resident 2 was noted with a small (measurement not indicated) cut at the bottom of the lip and complained of pain on the right side of the face, head and left hand. During a review of Resident 2's Nursing Note dated 10/30/2025, timed at 8:45 p.m., the Nursing Note indicated Resident 2 reported that when (time unknown) he (Resident 2) turned off the television (TV) in the room, Resident 1 hit him. During an interview on 11/14/2025 at 11:42 a.m. with Resident 1, Resident 1 stated that he and Resident 2 were roommates. Resident 1 stated that on 10/30/2025 (does not recall the exact time), after dinner, while he was sitting on his bed watching TV, Resident 2 stood up from his wheelchair and came over to his (Resident 1's) side of the room and turned off his (Resident 1's) TV. Resident 1 stated that he grabbed Resident 2's hat and told Resident 2 to stop touching his TV. Resident 1 stated Resident 2 turned around and hit (Resident 1) with a closed fist on his chest and in turn he (Resident 1) punched Resident 2 with a closed fist in the face. Resident 1 stated that after he punched Resident 2, Resident 2 left the room. Resident 1 stated when Resident 2 returned, he (Resident 2) wheeled himself to his (Resident 1‘s) side of the room, stood up, walked over to him and swung the footrest at him, hitting him in the face, resulting in bleeding to the nose and thumb. During an interview on 11/14/2025 at 11:48 a.m. with Licensed Vocational Nurse 1 (LVN) 1, LVN 1 stated that a resident-to-resident altercation between Resident 1 and Resident 2 occurred on 10/30/2025 after dinner (does not recall exact time) during the 3 p.m.-11 p.m. shift (a work schedule from 3 p.m. to 11 p.m.) LVN 1 stated that prior to the incident Resident 2 approached LVN 1 and stated that his roommate's (Resident 1) TV was on and he wanted it off. LVN 1 stated that she explained to Resident 2 that Resident 1 has the right to have his TV on. LVN 1 stated that next thing she knew, she