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 09/05/2024
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)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. 49947 Based on interview and record review, the facility failed to obtain consents and inform the resident in advance of the risks and benefits of the psychotropic (medications capable of affecting the mind, emotions, and behavior) medications for one of three sampled residents (Resident 13). This deficient practice violated Resident 13's right to know about and make decisions about their medical care. Findings: During a review of Resident 13's Admission Record, the document indicated the facility admitted the resident on 11/15/2018 with diagnoses including encounter for orthopedic (relating to muscles and or bones) aftercare following surgical amputation (a surgery to remove all or part of a limb [arms or legs]), acquired absence of right leg below the knee (right leg amputation), and acquired absence of left leg below the knee(left leg amputation). During a review of Resident 13's History and Physical (H&P) dated 7/9/2024, indicated the resident had the capacity to understand and make decisions. During a review of Resident 13's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 7/11/2024, indicated the resident had intact cognition (mental action or process of acquiring knowledge and understanding), required set up/clean up assistance with eating, substantial assistance with all other activities of daily living (ADLs - activities related to personal care). During a review of Resident 13's Order Summary Report, the report indicated an order for the following: - Trazadone (medication used to treat depression [mood disorder that causes a persistent feeling of sadness and loss of interest]) 300 milligrams (mg - unit of measurement) by mouth at bedtime for manifested by inability to sleep, ordered on 7/8/2024. - Vraylar (antipsychotic medication- a medication used to treat psychosis [a mental condition in which thought, and emotions are so affected that contact is lost with external reality]) 1.5 mg by mouth at bedtime for verbalization of sadness, ordered on 7/8/2024. (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

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 09/05/2024

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West Valley Post Acute	7057 Shoup Ave West Hills, CA 91307

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 9/5/2024 at 12:55 p.m., with Registered Nurse 2 (RN 2), reviewed Resident 13's medical chart in regards to informed consents and confirmed by stating that there was no medication consent for the use of Trazadone and Vraylar. RN 2 stated the consent is extremely important prior to starting treatment especially because Resident 13 is alert and can make her own decisions. RN 2 further stated Resident 13 and all residents have the right to make medical decisions based on the information they receive about their care. During a review of the facility's policy and procedure (P&P) titled, Psychoactive/Psychotropic Medication Use, last reviewed 6/26/2024, the policy indicated prior to administration of a psychotropic medication, the prescribing clinician (doctor) will obtain informed consent from the resident (or as appropriate, the resident representative), and document the consent in the medical record. These drugs include, but are not limited to, drugs in the following categories: antidepressant. During a review of the facility's P&P titled, Resident Rights, last reviewed 6/26/2024, the policy indicated the resident has the right to be notified of his or her medical condition and of any changes in his or her condition; and to be informed of, and participate in, his or her care planning and treatment.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47883 Based on interview and record review, the facility failed to ensure a copy of a resident's Advance Directive (a written statement of a person's wishes regarding medical treatment) was kept in the resident's chart and easily retrievable for three of four sampled residents (Resident 83, 49, 18). This deficient practice has the potential to create confusion which could lead to conflict with the resident's wishes regarding his/her health care. Findings: a. During a review of Resident 83's Admission Record, the document indicated the facility admitted the resident on 9/1/2023 with diagnoses of cerebral vascular disease (condition that affect the blood vessels that supply blood to your brain), chronic kidney disease (a condition in which the kidneys are damaged and cannot filter blood well), and type two (2) diabetes mellites (a chronic condition that affects the way the body processes blood glucose [sugar]). During a review of Resident 83's Minimum Data Set (MDS- a standardized assessment and screening tool) dated 9/18/2023, the document indicated the resident had severely impaired cognition (mental abilities, including remembering things, making decisions, concentrating, or learning). The MDS also indicated the resident was totally dependent on two or more helpers for assistance with bed mobility, transfer, locomotion, dressing, eating, toilet use and personal hygiene. During a concurrent interview and record review on 9/5/2024 at 8:30 a.m., with the Assistant Director of Nursing (ADON), reviewed Resident 83's Advance Directive Acknowledgement form dated 9/4/2023. The ADON stated that Resident 83's Advance Directive Acknowledgement form indicated that Resident 83 had an advance directive. The ADON stated Resident 83's advance directive could not be found in Resident 83's clinical record. The ADON stated that a copy of Resident 83's advance directive should have been kept in the resident's chart to provide guidance to the facility staff about the resident's wishes. During an interview on 9/5/2024 at 3:30 p.m., with the Director of Nursing (DON), the DON stated that the copy of Resident 83's advance directive should have been kept in the resident's charts to ensure the resident's wishes would be carried out, and to provide guidance to the facility staff about the resident's wishes. b. During a review of Resident 49's Admission Record, the document indicated the facility admitted the resident on 12/16/2023 with diagnoses of displaced fracture of base of neck of right femur (a break in the uppermost part of thighbone, next to hip joint), epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures [sudden, uncontrolled body movements and changes in behavior that occur because of abnormal electrical activity in the brain]), and dysphagia (difficulty swallowing). During a review of Resident 49's History and Physical, dated 2/15/2024, the document indicated that the resident did not have the capacity to understand and make decisions. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 49's MDS dated [DATE], indicated the resident had severely impaired cognition. The MDS also indicated the resident was totally dependent on two or more helpers for assistance with bed mobility, transfer, locomotion, dressing, eating, toilet use and personal hygiene. During a review of Resident 49's care plan (a written document that summarizes a resident's needs, goals, and care/treatment) initiated on 2/14/2024, the document indicated Resident 49 had an advance directive and advance directive will be in the medical record at all the time. During a concurrent interview and record review on 9/5/2024 at 8:30 a.m., with the ADON, review Resident 49's Advance Directive Acknowledgement form. The ADON stated that Resident 49's Advance Directive Acknowledgement form indicated that Resident 49 had an advance directive. The ADON stated Resident 49's advance directive was not found in Resident 49's clinical record. The ADON stated that a copy of Resident 49's advance directive should have been kept in the resident's chart to provide guidance to the facility staff about the resident's wishes. During an interview on 9/5/2024 at 3:30 p.m., with the DON, the DON stated that the copy Resident 49's advance directive should have been kept in the resident's charts to ensure the resident's wishes would be carried out, and to provide guidance to the facility staff about the resident's wishes. 38469 c. During a review of Resident 18's Admission Record, the document indicated the facility admitted the resident on 4/7/2016 and readmitted the resident on 3/15/2024 with diagnoses that included hypertension (high blood pressure [the force of the blood pushing on the blood vessel walls is too high]), type 2 diabetes mellitus, and legal blindness. During a review of Resident 18's MDS dated [DATE], indicated the resident's cognitive skills for daily decision making was impaired and totally dependent on staff for toileting, shower, dressing and personal hygiene. During a concurrent interview and record review on 9/5/2024 at 9:44 a.m., with the ADON, reviewed Resident 18's Advance Directive Acknowledgement form dated 3/19/2024. The review of Resident 18's Advance Directive Acknowledgement form indicated that Resident 18 had executed an advance directive. Upon examining of Resident 18's electronic record and physical chart with the ADON, the ADON confirmed by stating that there was no copy anywhere in Resident 18's record of the actual advance directive. The ADON stated that if there is an existing advance directive, it should be kept in the physical chart so it can be referenced in case of an emergency. The ADON explained further that a copy of the advance directive must be readily accessible to ensure the resident's healthcare wishes are respected or followed otherwise the facility might be in violation of the resident's healthcare wishes. During an interview on 9/5/2024 at 3:30 p.m., with the DON, the DON stated that the copy of Resident 18's advance directive should have been kept in the resident's charts to ensure the resident's wishes would be carried out, and to provide guidance to the facility staff about the resident's wishes. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure titled, Advance Directive, last reviewed on 6/26/2024, the policy indicated, The resident has the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment. Advance directives are honored in accordance with state law and facility policy . the residents wishes are communicated to the resident's direct care staff and physician by placing the advance directive documents in a prominent, accessible location in the medical record and discussing the residents wishes in care planning meetings .

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Encode each resident’s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34659 Based on interview and record review, the facility failed to transmit a resident's Discharge Minimum Data Set (MDS, a standardized assessment and care screening tool) within 14 days after the Discharge MDS completion date for one of 48 sampled residents (Resident 27). This deficient practice had the potential to delay care and services for the resident. Findings: During a review of Resident 27's Admission Record, the document indicated the facility admitted the resident on 4/16/2024 with diagnoses that included right lower leg fracture (broken bone). During a review of the Resident 27's Census (the facility's record of admissions and transfers to hospital and returns to the facility), the document indicated Resident 27 was admitted to the facility on [DATE] and discharged from the facility on 4/18/2024. During a review of Resident 27's 5-day assessment (assessing a resident's abilities within being in the facility five days or less) MDS, dated [DATE], the document indicated the resident was moderately impaired in cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) with skills required for daily decision making. The MDS indicated that Resident 27 required moderated assistance (helper does less than half the effort) with toileting, showering, and dressing. During a concurrent interview and record review on 9/4/2024 at 3:21 p.m., with MDS Registered Nurse (MDSN), reviewed Resident 27's MDS Medicare 5-day assessment, dated 4/18/2024. MDSN stated the MDS indicated this was a five-day assessment and a discharge with an expected return by the resident. MDSN stated Resident 27 did not return to the facility. Reviewed the Submission Transmission Statement (a document with the date the MDS was accepted by the Centers of Medicare and Medicaid Services [CMS, a federal government agency that manages the Medicare and Medicaid programs, which provide health coverage to millions of Americans]) that indicated an acceptance date as 6/14/2024. MDSN stated the MDS was submitted to CMS the same day as the acceptance date which was 6/14/2024. MDSN stated the MDS should have been submitted within 14 days after completion and was not sure why it was not submitted during that time. MDSN stated it was important to transmit an MDS to CMS timely so CMS could track what is happening with Resident 27 and would not negatively affect the resident's admission to another facility. During an interview on 9/5/2024 at 1:16 p.m., with the Director of Nursing (DON), the DON stated Resident 27's MDS should have been submitted within 14 days after completion so that CMS will have an accurate assessment of the resident's condition and so that there is no interference with a resident's admission to another facility. (continued on next page)

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	During a review of the facility's policy and procedure titled, Electronic Transmission of the MDS, last reviewed 6/26/2024, the document indicated for the facility to follow CMS's Resident Assessment Instrument (RAI- a structured assessment tool used to evaluate nursing home residents) Manual version 3.0. During a review of the CMS RAI 3.0 Manual, dated 10/2019, the document indicated all comprehensive assessments and other MDS assessments must be submitted within 14 days of the MDS Completion Date.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38469 Based on interview, and record review, the facility failed to develop a comprehensive person-centered care plan (a plan for an individual's specific health needs and desired health outcomes) for one of two sampled residents (Resident 18) by failing to develop a comprehensive person-centered Care Plan for the activity needs (any activities that are intended to improve a resident's quality of life and promote their physical, cognitive, and emotional health) of Resident 18. This deficient practice had the potential for Resident 18 to not receive the necessary care and services to address and allow Resident 18 to participate in activities. Findings: During a review of Resident 18's Admission Record, the Admission Record indicated that Resident 18 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE], with diagnoses that included hypertension (high blood pressure), type 2 diabetes mellitus (a disease in which the resident's blood glucose, or blood sugar, levels are too high and the body is unable to lower the blood sugar levels) and legal blindness (inability to see). During a review of Resident 18`s Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 07/11/2024, the MDS indicated Resident 18's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was impaired. The MDS further indicated that Resident 18 was totally dependent on staff for toileting, showering, dressing and personal hygiene. During a concurrent interview and record review of Resident 18`s Care Plans from 3/15/24 to 9/5/24 with the Activity Director (AD) on 09/05/24 at 09:24 a.m., AD stated that that Resident 18 did not have any care plan developed for activities. The AD stated that a person-centered care plan for activity should be developed for a resident to address the resident's activity preferences. The AD stated that without the care plan there would be no set goals and resident specific interventions to meet the resident`s needs. The AD stated that for Resident 18, the care plan should include things such as strolls in the facility patio.  A review of the facility`s policy and procedures titled Care Plans-Comprehensive Person-Centered, last reviewed on 6/26/2024, indicated that A comprehensive , person-centered care plan should include measurable objectives and timetable to meet the resident`s physical, psychosocial and functional needs .

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38469 Based on interview, and record review, the facility failed to immediately (no later than 21 days after admission) develop a comprehensive person-centered care plan (a plan for an individual's specific health needs and desired health outcomes) for one of two sampled residents (Resident 91). Resident 91 received a physician order for the use of Apixaban (a type of anticoagulant [blood thinning] medication) on 6/23/24, a care plan for anticoagulants was not developed until 7/22/24. This deficient practice had the potential for Resident 91 to not receive the necessary care and services to address and prevent complications of anticoagulant therapy for Resident 91 such as excessive bleeding. Findings: During a review of Resident 91's Admission Record, the Admission Record indicated Resident 91 was admitted to the facility on [DATE] with diagnoses that included hypertension (high blood pressure), and long-term use of anticoagulants. During a review of Resident 91`s Minimum Data Set (MDS a standardized assessment and care screening tool) dated 07/11/2024, the MDS indicated Resident 91's cognitive skills (relating to the mental process involved in knowing, learning, and understanding things) for daily decision making was impaired. The MDS further indicated that Resident 91 required partial to moderate assistance with oral hygiene, upper body dressing, personal hygiene. During a review of Resident 91`s Physician Order dated 6/23/24, the Physician Order indicated an order for Apixaban (a type of anticoagulant) Oral Tablet five (5) milligrams (mg-unit of measure) one (1) tablet by mouth two times a day. During a concurrent interview and record review with the Assistant Director of Nursing (ADON) on 09/04/2024 at 2:35 p.m., the ADON reviewed Resident 91`s Care Plans from 6/23/2024 to 9/4/24. The ADON stated that Resident 1's care plan for Medication-Anticoagulant was developed on 7/22/24. The ADON stated that Resident 91's care plan for Anticoagulants should have been initiated when Apixaban was first ordered by the physician on 06/23/2024, and not 30 days after. The ADON stated that Apixaban has a black box warning (a label on a medication that indicates a serious safety risk) which requires interventions that will be outlined in Resident 91's care plan to mitigate the serious adverse effects of the medications. During a review of the facility`s policy and procedures titled, Care Plans-Comprehensive Person-Centered, last reviewed on 6/26/2024, the policy indicated, A comprehensive , person-centered care plan should include measurable objectives and timetable to meet the resident`s physical, psychosocial and functional needs .

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38469 Based on observation, interview, and record review the facility failed to meet professional standards of practice by 1. Failing to ensure a resident`s heart rate was measured prior to administration of Losartan (medication to treat high blood pressure) for one of four sampled residents (Resident 32). 2. Failing to ensure licensed nurses rotated (a method to ensure repeated injections are not administered in the same area) the insulin (a hormone that works by lowering levels of glucose [sugar] in the blood) injection sites for one of two sampled residents (Resident 13). These deficient practices had the potential to place Resident 32 at increased risk for bradycardia (a condition where your heart beats fewer than 60 beats s per minute) which could result to dizziness and increased risk for fall and injury; and placed Resident 13 at increased risk of developing lipodystrophy (a group of conditions characterized by a complete or partial loss of fat tissue. Findings: 1. During a review of Resident 32's Admission Record, the Admission Record indicated the facility admitted Resident 32 on 01/27/2017, with diagnoses including hypertension (high blood pressure) and gastroesophageal reflux disease (GERD-a digestive disease in which stomach acid or bile irritates the food pipe lining). During a review of Resident 32`s Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 02/02/2024, the MDS indicated Resident 32's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was intact . The MDS further indicated that Resident 32 required supervision from staff with oral hygiene, toileting hygiene, dressing and personal hygiene. A review of Resident 32`s Order Summary Report, indicated a physician`s order of Losartan Potassium Tablet 500 milligrams (mg-unit of measure) one (1) tablet by mouth one time a day and hold if Systolic Blood Pressure (SBP- the pressure in a resident's arteries [tube-shaped blood vessels that carry oxygen-rich blood from the heart to the body's tissues and organs] when your heart contracts [squeeze] and pumps blood out) or heart rate below 60 beats per minute (normal heart rate is between 60 and 100 beats per minute). During a concurrent observation and interview on 09/04/2024 at 10:07 a.m., observed Licensed Vocational Nurse 1 (LVN1) preparing to administer Losartan to Resident 32. Observe LVN 1 check Resident 32's blood pressure and then administer Losartan to Resident 32 without checking Resident 32's hear rate. LVN1 then stated that LVN 1 forgot to measure the heart rate of Resident 32 prior to administering Losartan. LVN 1 stated that Resident 32`s heart could have been low and by administering Losartan it could have resulted in Resident 32 experiencing bradycardia. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/5/2024 at 11:30 a.m., with the Assistant Director of Nursing (ADON), the ADON stated the nurses should follow the physician`s order to check the SBP and heart rate prior to administration Losartan to Resident 32. The ADON stated that Losartan can decrease the heart rate and if the heart rate was below 6o beats per minutes, the Losartan should have not been given. The ADON stated low heart rate can cause dizziness and can result to fall and injure the patient. During a review of the facility's policy and procedure titled, Administering Medications, last reviewed on 6/26/2024, the policy indicated, Medications are administered in a safe and timely manner, and as prescribed .the following information is checked/verified for each resident prior to administering medications: B. Vital signs, if necessary . 49947 2. During a review of Resident 13's Admission Record, the Admission Record indicated Resident 13 was initially admitted on [DATE] with diagnoses including type 2 diabetes mellitus (DM II - a long-term condition in which the body has trouble controlling blood sugar and using it for energy). During a review of Resident 13's MDS dated [DATE], the MDS indicated Resident 13 had intact cognition. The MDS indicated that Resident 13 required substantial assistance from staff with activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During a review of Resident 13's Order Summary Report, the Order Summary Report indicated Resident 13's physician ordered for insulin Tresiba (a long-acting insulin injection that helps control blood sugar levels over a period of time) subcutaneous (fat tissue) solution pen-injector 200 unit/milliliter (ml - unit of measurement), inject 30 units subcutaneously one time per day dated 7/8/2024. During a review of Resident 13's Care Plan (CP) titled, Medication Hypoglycemic (medication to lower blood sugar), dated 9/3/2024, the CP indicated to administer insulin as ordered and to rotate injection sites. During a review of Resident 13's Diabetic Administration Record for 7/1/2024 to 9/5/2024, the Diabetic Administration record it indicated Tresiba subcutaneous solution pen-injector 200 unit/milliliter was administered as follows: 7/10/2024 at 8:53 a.m. on the abdomen - right lower quadrant. 7/11/2024 at 9:00 a.m. on the abdomen - right lower quadrant. 7/14/2024 at 9:20 a.m. on the abdomen - left lower quadrant. 7/15/2024 at 9:01 a.m. on the abdomen - left lower quadrant. 7/16/2024 at 9:24 a.m. on the abdomen - left lower quadrant. 8/1/2024 at 9:02 a.m. on the abdomen - right lower quadrant. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8/2/2024 at 9:03 a.m. on the abdomen - right lower quadrant. 8/8/2024 at 8:40 a.m. on the abdomen - left lower quadrant. 8/9/2024 at 8:54 a.m. on the abdomen - left lower quadrant. 8/11/2024 at 8:53 a.m. on the arm - left. 8/12/2024 at 8:17 a.m. on the arm - left. 8/13/2024 at 9:13 a.m. on the arm - left. 8/18/2024 at 8:41 a.m. on the abdomen - right lower quadrant. 8/19/2024 at 9:56 a.m. on the abdomen - right lower quadrant. 8/28/2024 at 9:24 a.m. on the abdomen - right lower quadrant. 8/29/2024 at 9:19 a.m. on the abdomen - right lower quadrant. During a concurrent interview and record review on 9/5/2024 at 12:40 p.m., with Medical Records 1 (MR 1), MR 1 reviewed Resident 13's Diabetic Administration Record and stated that the insulin injection sites were not being consistently rotated by the licensed nurses. During a concurrent interview and record review on 9/5/2024 at 12:55 p.m. with Registered Nurse 2 (RN 2), RN 2 reviewed Resident 13's Diabetic Administration Record and stated there were multiple instances where the injection sites of insulin were not rotated from 7/2024 to 9/2024 by the licensed nurses. RN 2 stated the nurse must rotate the insulin injection site to reduce the risk for lipo-hypertrophy and bruising. During a review of the facility's policy and procedure (P&P) titled, Insulin Administration last reviewed 6/26/2024, the policy indicated that injection sites should be rotated.

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 09/05/2024
NAME OF PROVIDER OR SUPPLIER West Valley Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 7057 Shoup Ave West Hills, CA 91307	

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34659 Based on interview and record review, the facility failed to reassess one of 19 sampled resident's (Resident 156) pain level (the amount of pain a resident is experiencing), 30 minutes to one (1) hour after the administration of oxycodone (medication used to treat pain). This deficient practice increased the risk of Resident 156 having untreated and prolonged unrelieved pain. Findings: During a review of Resident 156's Face Sheet, the Face Sheet indicated Resident 156 was admitted to the facility on [DATE] with diagnoses that included lower back pain, and a wedge compression fracture (a type of spinal fracture [break in bone] that occurs when the front of a vertebra [small circular bones that form the spine] collapses, causing it to take on a wedge shape) of third lumbar (lower back) fracture. During a review of Resident 156's Minimum Data Set (MDS, an assessment and care screening tool) dated 9/04/2024, the MDS indicated that Resident 156 had modified independence (some difficulty in new situations only) in cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) with skills required for daily decision making. The MDS indicated that Resident 156 was dependent (helper does all of the effort) with toileting, dressing, and personal hygiene. During a review of Resident 156's Physician's Orders, the Physician Order indicated an order for oxycodone oral tablet five (5) milligrams (mg, a unit of measure for medication), give one tablet by mouth every six hours as needed (PRN) for moderate to severe pain (pain rated at 4 to 10 where 10 is the most intense level of pain and zero [0] being no pain). During a review of Resident 156's Medication Administration Record (MAR, a report detailing the drugs administered to a resident by the licensed nurse in the facility), the MAR indicated Resident 156 received oxycodone 5mg on 9/03/2024 at 9:47 a.m., there was no documented evidence noted in the MAR that Resident 156's pain level was reassessed 30 minutes to one (1) hour after the 9:47 a.m. administration of oxycodone. During a concurrent interview and record review with the Minimum Data Set Nurse (MDSN) on 9/05/2024 at 10 a.m. reviewed Resident 156's Nursing Progress Notes dated 9/03/2024 and MAR dated 9/3/2024. MDSN stated that Licensed Vocational Nurse 4 (LVN 4) administered oxycodone 5 mg to Resident 156 on 9/3/2024 at 9:47 a.m. MDSN stated after reviewing Resident 156's MAR dated 9/3/24 and Nursing Progress Notes dated 9/3/24 that there was no pain reassessment done for Resident 156 after thee 9:47 a.m. administration of oxycodone on 9/3/24. MDSN stated that licensed nurses are to reassess a resident 30 minutes to one (1) hour after administering pain medications to ensure that the pain of the resident is relieved. (continued on next page)

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	055443	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Valley Post Acute	7057 Shoup Ave West Hills, CA 91307

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review with LVN 4 on 9/05/2024 at 11:07 a.m., reviewed Resident 156's Nursing Progress Notes, dated 9/03/2024 and MAR for 9/3/24. LVN 4 stated that LVN 4 was unable to find documentation of Resident 156's pain reassessment after the administration of oxycodone on 9/3/24 at 9:47 a.m. During a reviewed the facility's policy and procedure titled, Pain Assessment and Management, last reviewed 6/24/2024, the policy indicated acute (new onset) pain should be assessed every 30 to 60 minutes after the onset and reassessed as indicated until relief is obtained.

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NAME OF PROVIDER OR SUPPLIER West Valley Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 7057 Shoup Ave West Hills, CA 91307	

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. 47883 Based on observation, interview, and record review, the facility failed to ensure one of four sampled residents (Resident 32) received needed dental services. This deficient practice placed Resident 32 at increased risk for deterioration of oral hygiene and gum disease (bacteria attacks the gums, causing swelling and bleeding) Findings: During a review of Resident 32's Admission Record, the Admission Record indicated that the facility admitted Resident 32 on 1/27/2017 with diagnoses including chronic obstructive pulmonary disease (COPD-a group of diseases that cause airflow blockage and breathing-related problems) and essential hypertension (high blood pressure). During a review of Resident 32's Minimum Data Set (MDS-a care screening tool) dated 8/2/2024, the MDS indicated that Resident 32 had intact cognition (undamaged mental abilities, including remembering things, making decisions, concentrating, or learning). The MDS further indicated that Resident 32 needed supervision for showering, dressing, oral and toileting hygiene. During a review of Resident 32's Physician Orders dated 9/5/2024, noted was a physician order for dentistry consult with follow up treatment PRN (as needed) dated 01/27/2017. During a review of Resident 32's Dental Note dated 5/14/2024, the Dental Note indicated that all filling (a treatment that repairs a cavity or hole in a tooth by filling the space with a material after removing decayed tooth tissue) to be done at once when approval for the retreatment and the crown (a tooth-shaped cap) received. During concurrent interview and record review on 9/4/2024 at 1:48 p.m., with the Social Service Director (SSD), reviewed Resident 32's dental notes dated 2/27/2024, 3/20/2024, 4/4/2024, 4/17/2024, and 5/14/2024. The SSD stated that there was no documentation about Resident 32's approval for treatment of fillings and treatment for Resident 32's crown after 5/14/24. During an interview on 9/5/2024 at 3:30 p.m., with the Director of Nursing (DON), the DON stated that follow up dental visits need to be done in the timely manner to prevent residents' tooth infection and or further deterioration of the oral health. A review of the facility's policy and procedure titled, Dental services, last revised in 6/2024, indicated: Routine and emergency dental services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care.

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 47883 Based on observation, interview, and record review, the facility failed to prepare pureed (consists of food that have been blended into smooth, soft consistency) egg noodles according to the facility recipe on 9/4/2024 for 14 of 100 residents who are on a pureed diet. This deficient practice had a potential for residents who are on pureed diet not to eat the served food and could potentially lead to weight loss. Findings: During concurrent observation and interview on 9/4/2024 at 11 a.m., observed [NAME] 1 (C1) preparing pureed egg noodles for lunch. C1 stated that C1 was preparing 14 portions of pureed egg noodles for lunch. C1 stated that each portion of noodles was four (4) ounces (oz.-unit of measurement). C1 stated that C1 is using cooked noodles with chicken broth. Observed C1 add four oz of chicken broth. Observed C1 add milk to the blender (an electrical kitchen appliance used for mixing liquids and soft foods together) without first measuring the amount of milk. When C1 was asked how much milk was added to the blender, C1 stated around three to four oz of milk. Observe C1 then measure eight oz (also equivalent to 240 grams [gm-unit of measure]) of stabilizer (an ingredient used to maintain the texture of the food after it has been pureed). During concurrent interview and record review on 9/4/2024 at 11 a.m., with the Dietary Director (DD), the DD reviewed the facility's puree pasta recipe. The DD stated that the facility's puree pasta recipe indicated that for 14 serving of pasta the following is to be used: - 14 to 24 oz of milk - Seven to 12 tablespoons (70-120 gram) of stabilizer - No Chicken broth The DD stated that by C1 not following the facility recipe, the palatability (the quality of being tasty) and nutritional value of the food would be affected. During a concurrent observation and interview on 9/4/25 at 2:05 p.m., with DD, observed DD sampled a puree lunch tray for the egg noodles. DD stated that the egg noodles was not palatable and tasted like too much stabilizer was used. During an interview on 9/5/2024 at 3:30 p.m., with the Director of Nursing (DON), the DON stated that all food in the facility should be prepared according to the facility's recipes to ensure the nutritional value and palatability of the food. The DON stated that by not following the food recipes, the nutritional value of the food would be affected and could possibly lead to residents' weight loss. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Food and Nutrition, dated 6/2024, the policy indicated that each resident is to be provided with a nourishing , palatable , well-balanced diet that meets his or her daily nutritional and special dietary needs.

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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. 47883 Based on observation, interview, and record review, the facility failed to store food in accordance with professional standards by not labeling food stored with a use by date. These deficient practices had the potential for 98 of 100 residents who receive food from the facility kitchen to be at risk for food borne illness (illness caused by food contamination with bacteria, viruses, parasites, or toxins). Findings: During a concurrent observation and interview on 9/3/2024 at 8:00 a.m., with the Dietary Director (DD), observed in the storage room one container of instant pudding mixes, five pounds (lbs. - unit of measurement) of corn bread mixes, six lbs. of brownies mixes, four lbs. of cheesecake mixes, one clear container of premium topping, seven boxes of seedless raisins, one clear container of instant pudding mixes, four boxes of premium beef flavor soup, and three boxes of premium chicken flavor soup not labeled with a use by date. The DD stated there should have been a label with a use by date and if there was not, that could affect the residents and the residents could get sick. During an interview on 8/5/2024 at 3:30 p.m., with the Director of Nursing (DON), the DON stated food should have been labeled with a use by date and should have always had a use by date label. The DON stated if the food was not labeled, the food could go bad, and the facility would want to prevent that. A review of facility's policy and procedure (P&P) titled, Food receiving and Storage dated November 2022 indicated Dry food that are stored in bins are removed from original packing , labeled and dated.

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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** 38549 Based on observation, interview, and record review, the facility failed to ensure that 27 of 49 resident rooms (room [ROOM NUMBER], 2, 3, 5, 7, 9, 15, 17, 19, 21, 23, 25, 26, 28, 30, 31, 36, 37, 39, 41, 42, 43, 44, 45, 46, 47, and 48) met the square footage requirement of 80 square feet (sq. ft. - unit of measurement) per resident in multiple resident rooms. The room size for these rooms had the potential to have inadequate space for resident care and mobility. Findings: During the recertification survey from 9/3/2024 to 9/5/2024, it was observed that the residents residing in the rooms with an application for variance had sufficient amount of space for residents to move freely inside the rooms. There was adequate room for the operation and use of wheelchairs, walkers, or canes. The room variance did not affect the care and services provided by nursing staff for the residents. On 9/3/2024, the Administrator submitted the application for the Room Variance Waiver for 27 resident rooms. The room variance letter indicated that these rooms did not meet the 80 square feet per resident requirement per federal regulation. The room waiver request showed the following: Room # Square Footage Number of Beds 1 235.7 3 2 235.7 3 3 235.7 3 5 235.7 3 7 235.7 3 9 235.7 3 15 235.7 3 17 235.7 3 19 235.7 3 21 235.7 3 23 235.7 3 (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	25 235.7 3 26 235.7 3 28 235.7 3 30 235.7 3 31 235.7 3 36 235.7 3 37 235.7 3 39 235.7 3 41 235.7 3 42 235.7 3 43 235.7 3 44 235.7 3 45 235.7 3 46 235.7 3 47 235.7 3 48 235.7 3 The minimum requirement for a 2-bedroom should be at least 160 sq. ft. The minimum requirement for a 3-bedroom should be at least 240 sq. ft. The minimum requirement for a 4-bedroom should be at least 320 sq. ft. A review of the room waiver letter, dated 3/26/2024, indicated that each room listed on the Client Accommodation Analysis had no projections or other obstruction, which may interfere with free movement of wheelchairs and/or sitting devices. The letter indicated that there is enough space to provide for each resident's care, health and safety, and dignity nor will it impede the ability of any resident in the rooms to attain his or her highest practicable well-being.