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	08/14/2025

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review, the facility failed to provide care in a manner that maintained a resident's dignity by failing to provide privacy during indwelling urinary catheter (a flexible tube inserted into the bladder [organ that stores urine] and left in place to continuously drain urine) care for two of five sampled residents (Resident 44 and 15). This deficient practice had the potential to negatively affect the residents' psychosocial (refers to the interplay between psychological factors [thoughts, feelings, behaviors] and social factors [relationships, environment, culture]) wellbeing and loss of dignity. Findings: a. During a review of Resident 44’s admission Record, the admission Record indicated the facility initially admitted Resident 44 on 7/20/2022 and readmitted the resident on 6/15/2024 with diagnoses that included, but not limited to Alzheimer’s disease (a disease characterized by a progressive decline in mental abilities), aphasia (a disorder that makes it difficult to speak), and neuromuscular dysfunction of the bladder (nerve damage that causes the inability to control urination normally). During a review of Resident 44’s Minimum Data Set (MDS, a resident assessment tool) dated 5/20/2025, the MDS indicated Resident 44 usually understood others and was usually able to make herself understood. The MDS indicated Resident 44 was dependent on facility staff for all activities of daily living (ADLs - activities such as bathing, dressing and toileting a person performs daily). During a concurrent observation and interview on 8/13/2025 at 10:32 a.m., with Certified Nurse Assistant (CNA 6) in Resident 44’s room, CNA 6 began providing care to Resident 44’s urinary catheter without providing privacy. Resident 44’s bed was closest to the hallway, the door to the room was open, and Resident 44’s curtain was open in full view of the hallway. CNA 6 stated prior to providing care for any resident, she (CNA 6) must close the curtain to provide privacy, but she forgot to close the curtain this time. CNA 6 stated privacy is important for the residents’ dignity. During an interview on 8/14/2025 at 1:36 p.m., with the Director of Nursing (DON), the DON stated every resident has the right to privacy and staff must provide privacy while giving care. The DON further stated CNA 6 should have either closed the door or pulled the curtain completely shut prior to providing urinary catheter care to respect Resident 44’s dignity and privacy. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) titled, Confidentiality of Information and Personal Property, last reviewed on 6/25/2024, the policy indicated it is the practice of the facility to protect and safeguard resident confidentiality and personal privacy. The P&P further states the facility will strive to protect the resident’s privacy regarding his or her accommodations, medical treatments and personal care. b. During a review of Resident 15’s admission Record, the admission Record indicated the facility originally admitted Resident 15 on 2/8/2025 and re-admitted the resident on 7/12/2025 with diagnoses including hypertension (high blood pressure [the force of the blood pushing on the blood vessel walls is too high]), depression (mood disorder that causes a persistent feeling of sadness and loss of interest), and neuromuscular dysfunction of the bladder. During a review of Resident 15’s History and Physical (H&P) dated 7/14/2025, the H&P indicated Resident 15 had the capacity to understand and make decisions. During a concurrent interview and observation on 8/12/2025 at 2:40 p.m., in Resident 15’s room with Licensed Vocational Nurse 1 (LVN 1), observed LVN 1 did not close the curtain and provide privacy for Resident 15 before the start of urinary catheter care. LVN 1 stated that she (LVN 1) should have closed the curtain before the start of care for Resident 15. LVN 1 stated that Resident 15’s body and/or care could have potentially been exposed to other residents and/or staff. LVN 1 stated that all residents have the right to privacy and privacy should be provided for all residents while receiving care. LVN 1 stated that not providing residents with privacy can have an impact on residents’ psychological wellbeing which can potentially lead to psychosocial harm if felt embarrassed. During an interview on 8/14/2025 at 1:55 p.m., with the Director of Nursing (DON), the DON stated that all residents have the right to privacy while residing in the facility. The DON stated Resident 15’s curtain should have been closed by the nurse prior to providing care or assessing Resident 15’s urinary catheter. The DON stated that not providing privacy for Resident 15 could have potentially caused the resident to have felt embarrassed or potentially have had an impact on Resident 15’s psychological wellbeing. The DON stated that staff should treat all residents with respect and dignity at all times. During a review of the facility’s policy and procedure (P&P) titled, “Resident Rights,” dated 6/2025, the P&P indicated, “Employees shall treat all residents with kindness, respect, and dignity. 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident’s right to: d. Privacy and confidentially.”

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, and record review, the facility failed to ensure that a call light (a device used by a patient to signal his or her need for assistance from a professional staff) was within reach for one of three sampled residents (Resident 83) investigated under the environment facility task. This deficient practice had the potential to result in Resident 83 not being able to call for facility staff assistance and delay in the provision of necessary care and services that can negatively affect the residents' comfort and well-being.Findings: During a review of Resident 83's admission Record, the admission Record indicated the facility admitted the resident on 3/8/2024 with diagnoses including unspecified dementia (a progressive state of decline in mental abilities), dysphagia (difficulty swallowing), and a history of falling. During a review of Resident 83's Minimum Data Set (MDS - an assessment and care screening tool) dated 6/11/2025, the MDS indicated Resident 83 usually makes herself understood and usually understands others. The MDS further indicated Resident 83 needs supervision with toileting, showering, dressing and putting on and taking off shoes. During a review of Resident 83's Care Plan with a focus of Resident had a fall and was noted with confusion initiated on 7/13/2024, the care plan indicated an intervention to keep call light within reach and encourage to use it for assistance. During an observation on 8/11/2025 at 9:51am in Resident 83's room, Resident 83 was up in her wheelchair on the left side of her bed, near the foot of the bed. The call light was wrapped and hung on the right upper side rail, completely out of the resident's reach. During a concurrent observation and interview on 8/11/2025 at 9:57 a.m. inside Resident 83's room with Certified Nursing Assistant (CNA 7), CNA 7 stated she forgot to place the call light next to Resident 83. CNA 7 stated the call light should not be wrapped up on the upper side rail on the opposite side of the bed, but next to the resident so she could call for help and there would not be a delay of care. During an interview on 8/14/2025 at 2:15 p. m., with the Director of Nursing (DON), the DON stated all call lights should be within each resident's reach so staff would be able to attend to their needs timely at all times. The DON further stated Resident 83 has a history of falls and she was at risk of possible injury if the call light is not next to her. During a review of the facility's policy and procedure (P&P) titled, Answering the Call Light, last reviewed 6/25/2025, the P&P indicated staff must answer timely to the resident's request and needs. The P&P further indicated staff must ensure the call light is accessible to the resident.

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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 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. (continued on next page)

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to:1. Notify residents of the location of results of the most recent survey (means the Statement of Deficiencies [Form CMS-2567] generated by the most recent standard survey and any deficiencies resulting from any subsequent complaint investigation(s) for five (Resident 20, Resident 33, Resident 34, Resident 42, and Resident 88) who attended the resident council meeting.2. Post in a place readily accessible (is a place [such as a lobby or other area frequented by most residents, visitors or other individuals] where individuals wishing to examine survey results do not have to ask to see them) to residents and family members and legal representatives of residents, the results of the most recent survey of the facility.This had the potential for residents and family members not to know how the facility is performing in regard to resident care. Findings:1.a. During a review of Resident 20's admission Record (or Face Sheet, front page of the chart that contains a summary of basic information about the resident), the admission Record indicated that the facility admitted the resident on 11/19/2024 with diagnoses including hypertension (high blood pressure). During a review of Resident 20's Minimum Data Set (MDS, a resident assessment tool), dated 5/22/2025, the MDS indicated Resident 20 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 Resident 20 required supervision with eating. b. During a review of Resident 33's admission Record, the admission Record indicated that the facility admitted the resident on 2/07/2019 with diagnoses including hypertension.During a review of Resident 33's MDS, dated [DATE], the MDS indicated Resident 33 was moderately impaired in cognition with skills required for daily decision making. The MDS indicated Resident 33 required supervision with eating and oral hygiene. c. During a review of Resident 34's admission Record, the admission Record indicated that the facility admitted the resident on 9/12/2019 with diagnoses including transient ischemic attack (a brief stroke-like attack, including weakness on one side of the body).During a review of Resident 34's MDS, dated [DATE], the MDS indicated Resident 34 was cognitively intact with skills required for daily decision making. The MDS indicated Resident 34 required supervision with eating and oral hygiene. d. During a review of Resident 42's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE], with diagnoses including femur fracture (a break in the thigh bone).During a review of Resident 42's MDS, dated [DATE], the MDS indicated Resident 42 was moderately impaired in cognition with skills required for daily decision making. The MDS indicated Resident 33 required supervision with eating and oral hygiene. e. During a review of Resident 88's admission Record, admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses including muscle weakness. During a review of Resident 88's MDS, dated [DATE], the MDS indicated Resident 88 was severely impaired in cognition with skills required for daily decision making. The MDS indicated Resident 88 required supervision with eating. 2. During the survey resident council meeting on 8/12/2025 at10:30 a.m., all five of the resident council residents interviewed stated they did not know there were written survey results conducted by Department of Public Health or where the results were located.During an observation on 8/12/2025 at 11:29 a.m., observed the front desk area near the facility's front and side door with the Activities Director (AD). Did not observe any survey results located on the desk or nearby table located directly across from the front desk. Survey team walked towards the side door and looked back sharply to observe a white binder labeled, Annual Survey, on the desk. The survey results were not visible to anyone who would exit the facility front door or possibly the side door unless looking to the right as they exited the facility.During an interview and record review on 8/12/2025 at 11:34 a.m. with the AD, reviewed the contents of the Annual Survey binder. Verified with the AD, there were no survey results from 2024 and only one result of a complaint, dated 10/23/2024. During a concurrent interview and record review on 8/12/2025 at 12:15 p.m., reviewed the facility's policy and procedure, titled, Survey Results, Examination of, last reviewed 6/25/2025, with the AD. The policy indicated a copy of the most recent survey report, and any plans of correction are kept in a binder accessible to residents, family members, resident representatives and to the public. The AD stated accessible meant within sight, not on the desk, behind the counter, where most people could not see the binder. The policy indicated survey reports, certifications, complaint investigations and plans of correction for the preceding three years are available for any individual to review upon request. Reviewed the Survey Binder with the AD. The AD stated the binder was incomplete in that it did not contain all of the last three

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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. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a copy of the resident's Advance Directive (AD- a legal document indicating resident preference on end-of-life treatment decisions) was kept in the resident's medical chart and easily retrievable for two of three sampled residents (Resident 3 and 35) reviewed under the Advanced Directive care area. This deficient practice had the potential to create confusion which could lead to conflict with the resident`s wishes regarding their health care.Findings: a. During a review of Resident 3's admission Record (Face Sheet), the admission Record indicated that the facility initially admitted the resident on 8/24/2023 and readmitted on [DATE] with diagnoses including acute (sudden) and chronic (over time) congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), unspecified dementia (a progressive state of decline in mental abilities) and type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 3's Minimum Data Set (MDS - a resident assessment tool) dated 7/28/2025, the MDS indicated that Resident 3 usually understood others and usually makes himself understood. The MDS indicated that Resident 3 was dependent on staff for toileting showering/bathing, dressing, and putting on/taking off footwear. During a review of Resident 3's Physician Order for Life-Sustaining Treatment (POLST - a form that contains written medical orders for healthcare professionals regarding specific medical treatments that can or cannot be done at the end of life) dated 10/20/2024, the POLST indicated Resident 3 had an AD dated 3/15/2019. During a concurrent interview and record review on 8/12/2025 of Resident 3's medical chart at 9:38 am at the nurse's station 2 with the Medical Records Assistant (MRA), the MRA pointed to the POLST and stated Resident 3 had an AD. The MRA continued to look through Resident 3's medical chart and could not locate his AD. The MRA stated a physical copy of the AD should be in Resident 3's medical record. During an interview on 8/14/2025 at 2:38 pm, with the Director of Nursing (DON), the DON stated that if a resident has an AD, a copy of the resident`s AD should be kept in the resident's physical medical chart for staff to have easy access The DON stated the potential outcome for not having Resident 3's AD in his physical chart was for staff to possibly not honor his wishes. b. During a review of Resident 13's admission Record (Face Sheet), the admission Record indicated that the facility initially admitted the resident on 10/11/2022 and readmitted on [DATE] with diagnoses including Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), epilepsy (disorder characterized by recurrent, unprovoked seizures [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness]) and history of falling. During a review of Resident 13's MDS dated [DATE], the MDS indicated that Resident 13 understands others and makes himself understood. The MDS indicated that Resident 13 required supervision from staff for eating, oral hygiene, upper body dressing and personal hygiene. During a review of Resident 13's POLST dated 7/31/2025, the POLST indicated Resident 13 had an AD dated 8/9/2016. During a concurrent interview and record review on 8/12/2025 of Resident 13's medical chart at 9:44 am at the nurse's station 2 with the Medical Records Assistant (MRA), the MRA pointed to the POLST and stated Resident 13 had an AD. The MRA continued to look through Resident 13's medical chart and could not locate his AD. The MRA stated a physical copy of the AD should be in Resident 13's medical record. During an interview on 8/14/2025 at 2:43 pm, with the DON, the DON stated that if a resident has an AD, a copy of the resident`s AD should be kept in the resident's physical medical chart for staff to have easy access. The DON stated the potential outcome for not having Resident 13's AD in his physical chart was for staff to possibly not honor his wishes. During a review of the facility`s Policy and Procedure (P&P) titled Advanced Directives, last reviewed on 6/25/2025, the P&P indicated if the resident or resident's representative has executed one or more advance directive(s), or executes one upon admission, copies of these documents are obtained and maintained in the same section of the resident's medical record and readily retrievable by any facility staff.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review the facility failed to notify the resident's physician of a change of condition (COC, decline or improvement in a resident's status that will not resolve itself without intervention) in accordance with physician's orders for one of two residents (Resident 12) reviewed who were prescribed insulin (hormone that regulates blood sugar levels) by failing to: 1. Notify the physician when Resident 12's blood sugar was over 300. 2. Notify the physician when Resident 12' blood sugar was over 400 and change in condition form was not filled out. This had the potential for Resident 12 to suffer complications from elevated blood glucose such as infection and diabetic coma (a complication of diabetes where a person loses consciousness due to extremely high blood sugar levels).Findings:During a review of Resident 12's admission Record, the admission Record indicated the facility admitted the resident on 6/02/2025 with diagnoses including diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing) and contact dermatitis (a skin condition caused by direct contact with an irritant or allergen, resulting in rash and inflammation). During a review of Resident 12's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 6/12/2025, the MDS indicated Resident 12 was severely 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 Resident 12 was dependent on staff for personal hygiene. During a review of Resident 12's Physician's Orders, the Physician Orders indicated the following:- Humalog KwikPen Subcutaneous Solution (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) 100 units/milliliter (units/ml, used for insulin dosage and/or amount) inject as per sliding scale:If 70 - 150 milligrams/deciliter (mg/dL, a unit of measure for blood sugar) mg/dL, then give no units; If blood sugar is less than (<) 70 mg/dL, give orange juice then re-check after 15 minutes, notify the physician.If 151 - 200 mg/dL, then give 2 units;If 201 - 250 mg/dL, then give 4 units;If 251 - 300 mg/dL, then give 6 units;If 301 - 350 mg/dL, then give 8 units;If 351 - 400 mg/dL, then give 10 units;If 401 - 450 mg/dL, then give 12 units; for blood sugar 400 mg/dL and above, give dose, then notify physician, subcutaneously (into the fat right under the skin) four times a day for DM, dated 6/02/2025.-Humalog Injection Solution, inject 8 units subcutaneously three times a day for DM, dated 6/26/2025.-Insulin Glargine Solution Pen Injector, 100 mg/ml, inject 25 units subcutaneously one time a day for DM, dated 7/06/2025.-Monitor blood sugar twice a day, inform the physician if the blood sugar is below 70 mg/dL or above 300 mg/dl (normal reference range is 70 - 100 mg/dL), for DM, dated 6/03/2025.During a review of Resident 12's Care Plan for Diabetes, initiated 6/13/2025, the care plan indicated a goal that Resident 12 will be free of signs or symptoms associated with hypoglycemia (low blood sugar) or hyperglycemia (high blood sugar).The care plan indicated the following interventions:- Administer medications as ordered- Blood glucose checks as ordered. Report to the physician if blood glucose is outside of set parameters.- Monitor for signs of hyper/hypoglycemia (i.e., change in level of consciousness, diaphoresis (sweating), dizziness, headache, hunger, shakiness, etc. During a review of Resident 12's Medication Administration Record (MAR, a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for the month of 7/2025 and 8/2025, covering the dates 7/01/2025 through 7/31/2025 and 8/01/2025 through 8/13/2025, the MAR indicated the following:7/2025 above 300 mg/dL were 8 instances8/2025 above 300 mg/dL were 10 instances.During a review of Resident 12's 8/2025 MAR, the MAR indicated Resident 12's blood sugar was 424 mg/dL on 8/10/2025 at 11 a.m.During a concurrent interview and record review with Licensed Vocational Nurse 4 (LVN 4) on 8/13/2025 at 4:30 p.m., reviewed Resident 12's 8/2025 MAR. LVN 4 stated that he took the fingerstick on 8/12/2025 and was 357 mg/dL. LVN 4 stated he did not notify Resident 12's physician because he follows the Humalog sliding scale in which the physician should be notified if the fingerstick is greater than 400. Observed LVN 4's computer in which LVN 4 demonstrated how he documents that a medication has been given. Observed the order indicated to notify MD if blood sugar is over 300. LVN 4 verified that he has to press yes to indicate it has been completed but did not notice this order but clicked yes. LVN 4 stated he should notify the RN supervisor and call Resident 12's physician to clarify the order.During a concurrent interview and record review with the Minimum Data Set Coordinator (MDSC) on 8/14/2025 at 10:09 a.m., reviewed Resident 12's Physician Orders, one indicating to notify the physician if the blood sugar is greater than (>) 300 mg/dL and one if blood sugar is > 400 mg/dL. Reviewed Resident 12's 7/2025 MAR and confirmed with the MDSC that there were eight instances in which Resident 12's blood sugar was over 300

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. Based on observation, interview, and record review, the facility failed to ensure the confidential personal information of residents were protected by failing to ensure documents containing protected health information ([PHI]- any health information that can be used to identify a specific individual which must remain confidential to prevent harmful consequences) were not shredded prior to disposing in the waste container. This failure had the potential to violate 100 of 101 residents' rights for privacy and confidentiality of personal and medical records.Findings: During an observation on 8/12/2025 at 9:30 a.m. of the dishwashing process with Dietary Aide 1 (DA 1) in the three-compartment sink, observed DA 1 threw the residents meal tickets on the trash. The meal tickets had residents' names, room numbers, diet orders, and food allergies information. During a concurrent observation and interview on 8/12/2025 at 9:51 a.m. of the dishwashing process with DA 1 and the DS, the DS stated DA 1 threw all the meal tickets in the trash can and the trash gets thrown outside in the dumpster. The DS stated the meal tickets contained the residents' personal information because it had the residents' name, diet, room number and food preferences. The DS stated this practice should not be done and the diet tickets should be placed in a confidential bin for shredding services to pick up. The DS stated the residents' information was exposed and someone could potentially misuse the residents' information. The DS stated they have violated resident privacy under Health Insurance Portability and Accountability Act (HIPAA, a federal law that sets national standards to protect medical records and personal health information). During an interview on 8/12/2025 at 2:38 p.m. with the Director of Nursing (DON), the DON stated resident's records, diagnosis, medication, current level of care, social security number, date of birth , name and diet order are some of the health protected information. The DON stated the following are ways to protect PHI:1. Printed paper containing resident's information must be placed at the proper disposal for shredding.2. Block the names and information of the residents prior to disposing of the documents.3. Facility would not post anything in the room that violates resident's rights.The DON stated the kitchen staff should not be throwing the meal tickets in the garbage as it contains name, room number, diet and allergies of the residents and it is considered protected information. The DON stated she was not aware the kitchen staff were throwing the diet tickets in the dumpster, and they should have a special bin to dispose of it for shredding. The DON stated they were not protecting residents' information. The DON stated that there is a risk that someone could use the resident's information inappropriately. During a review of the facility's policies and procedures titled Protected Health Information (PHI), Management and Protection Of dated 6/25/2025, the P&P indicated, Protected Health Information (PHI) shall not be used or disclosed except permitted by current federal and state laws. Policy and Interpretation:1. It is the responsibility of all personnel who have access to resident and facility information to ensure that such information is managed and protected to prevent unauthorized release or disclosure.2. When using or disclosing PHI, or when requesting PHI from another entity, reasonable efforts must be made to limit the PHI used or disclosed to the minimum necessary to accomplish the purpose of the use or disclosure of such information. 3. Health information must be considered not to be individually identifiable in the following circumstances:a. A person with appropriate knowledge and experience with generally acceptable statistical and scientific principles and methods to determine that the risk is very small that the information could be used, alone or with other reasonably available information, to identify the resident who is subject of the information; orb. The following identifiers of the resident (and relatives, employers or household members) are removed: i. Names ii. Any other unique identifying number or characteristic code.

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West Valley Post Acute	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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. (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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to accurately assess range of motion ([ROM] full movement potential of a joint) limitations in both legs for one of three sampled residents (Resident 55) with positioning and mobility (ability to move) concerns on four Minimum Data Set ([MDS] a federally mandated resident assessment tool) assessments, dated 10/31/2024, 1/31/2025, 4/30/2025, and 7/30/2025. This failure had the potential to affect the provision of Resident 55's care and provided inaccurate information to the Federal database. Findings: During a review of Resident 55's admission Record, the admission Record indicated the facility admitted Resident 55 on 10/23/2021 with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) following cerebral infarction (brain damage due to a loss of oxygen to the area) affecting the left non-dominant side, dysphagia (difficulty swallowing), muscle weakness, left upper arm contracture (a stiffening/shortening at any joint that reduces the joint's range of motion) of the muscle, and dementia (progressive state of decline in mental abilities). During a review of Resident 55's care plan titled, The resident is at risk for falls related to history of falls, initiated 10/24/2021 and revised on 11/13/2024, the care plan interventions included to anticipate and meet the resident's needs and provide a safe environment. During a review of Resident 55's physician's orders, dated 5/17/2024, the physician's order indicated for Restorative Nursing Aide ([RNA] nursing aide program that helps residents to maintain their function and joint mobility) to provide active assistive range of motion ([AAROM] use of muscles surrounding the joint to perform the exercise but requires some help from a person or equipment) to both legs. Another physician's order, dated 5/17/2024, indicated to apply a left resting hand splint (brace secured with straps that extends from the fingers to the forearm to properly position the fingers and wrist), left elbow extension splint (brace designed to help maintain or improve the range of motion at the elbow joint, specifically focusing on the ability to straighten or extend the arm), and both knee extension splints (brace designed to help maintain or improve the range of motion at the knee joint), seven times per day for two to three hours as tolerated. During a review of Resident 55's physician's orders, dated 6/7/2024, the physician's order indicated for RNA to provide passive range of motion ([PROM] movement of a joint through the range of motion with no effort from person) on the left arm, seven times per week as tolerated. During a review of Resident 55's MDS, dated [DATE], 1/31/2025, and 4/30/2025, the MDS indicated Resident 55 had functional ROM limitations (limited ability to move a joint that interferes with daily functioning or places the resident at risk of injury) in one arm and one leg. During a review of Resident 55's Physical Therapy ([PT] profession aimed in the restoration, maintenance, and promotion of optimal physical function) Evaluation and Plan of Treatment, dated 5/28/2025, the PT Evaluation indicated Resident 55 was referred to PT due to increased tightness on the left ankle. The PT Evaluation indicated Resident 55 had minimal ROM limitations (approximately 75 percent [%] of full ROM) in both knees and the left ankle. The PT Evaluation indicated Resident 55 required maximum assistance (required between 51-75% physical assistance) for sit-to-stand transfers and chair/bed-to-chair transfers. The PT Evaluation indicated Resident 55 was unable to walk. During a review of Resident 55's PT Discharge summary, dated [DATE], the PT Discharge Summary recommendations indicated for RNA to provide ROM exercises and apply both knee splints and the left pressure relief ankle foot orthoses ([PRAFO] device worn on the calf and foot to suspend the heel and hold the ankle in neutral [90 degree] position). During a review of Resident 55's physician's orders, dated 6/17/2025, the physician's orders indicated for RNA to apply the left PRAFO for two to two-and-a-half hours, seven days per week as tolerated. During a review of Resident 55's MDS, dated [DATE], the MDS indicated Resident 55 had clear speech, had difficulty communicating some words or finishing thoughts, usually understood verbal content, and had severely impaired cognition (ability to think, understand, learn, and remember). The MDS indicated Resident 55 required setup or clean-up assistance (helper sets up or cleans up while resident completes the activity, helper assists only prior to or following the activity) for eating and supervision or touching assistance (helper provides verbal cues and/or touching and/or steadying assistance as resident completes the activity) for upper body dressing. The MDS indicated Resident 55 required partial/moderate assistance (helper does less than half the effort) for rolling and sit-to-stand transfers and substantial/maximal assistance (helper does more than half the effort) for lower body dressing and chair/bed-to-chair transfers. The MDS also indicated Resident 55 did not attempt to walk 10 feet (unit of measure) and did not perform this activity prior to the current illness. During an observation on 8/13/2025 at

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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 - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan (a document that summarizes a resident's needs, goals, and care/treatment) for three of four sampled residents (Resident 114, 11, and 12) by failing to: 1. Develop a care plan addressing Resident 114 and 11's use of antibiotic (medication that fights bacterial infections). 2. Implement and follow Resident 12's care plan addressing Resident 12's elevated blood sugar. These deficient practices had the potential to result in failure to deliver the necessary care and services.Findings: 1.a. During a review of Resident 114’s admission Record, the admission Record indicated that the facility admitted the resident on 8/4/2025 with diagnoses that included type two (2) mellitus diabetes (a chronic condition that affects the way the body processes blood glucose [sugar]), hypertension (high blood pressure [the force of the blood pushing on the blood vessel walls is too high]), and long-term use of antibiotics. During a review of Resident 114’s Minimum Data Set (MDS - a resident assessment tool) dated 8/7/2025, the MDS indicated the resident'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 impaired and the resident required substantial/maximal assistance with oral shower, upper body dressing, personal hygiene and totally dependent on staff for toileting hygiene, lower body dressing, and putting on and taking off footwear. During a concurrent interview and record review on 8/12/2025 at 2:17 p.m., with the Infection Preventionist Nurse (IPN), reviewed Resident 114`s physician orders and care plans. Resident 114’s physician orders indicated an order for Bactrim (an antibiotic used to treat various bacterial infections) oral tablet 800-160 milligram (mg- unit of measurement) one tablet by mouth one time a day every Monday, Wednesday, and Saturday for infection prophylaxis (action taken to prevent disease). Resident 114’s care plans indicated that there was no care plan developed for Resident 114’s use of Bactrim. The IPN explained that each time an antibiotic is ordered, a care plan must be developed to ensure the goal of treatment is identified and put in place interventions to monitor and prevent potential side effects or adverse effects (undesired harmful effect resulting from a medication or other intervention) of the antibiotic. During a review of the facility’s policy and procedure titled, Care Plans, Comprehensive Person-Centered, last reviewed on 6/25/2025, the policy indicated that A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident`s physical, psychosocial and functional needs is developed and implemented for each resident . assessments of residents are ongoing and care plans are revised as information about the residents and the resident`s condition changes… 1.b. During a review of Resident 11's admission Record, the admission Record indicated that the facility originally admitted the resident on 6/27/2021 and readmitted the resident on 10/16/2024 with diagnoses that included type two (2) mellitus diabetes, hypertension, and muscle wasting and atrophy (partial or complete wasting away of a part of the body). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 11's MDS dated [DATE], the MDS indicated the resident's cognitive skills for daily decision making were severely impaired and the resident required substantial/maximal assistance with toileting hygiene, shower, lower body dressing, putting on and taking off footwear, and personal hygiene. During a concurrent interview and record review on 8/12/2025 at 2:25 p.m., with the IPN, reviewed Resident 11`s physician orders and care plans. Resident 11’s physician orders indicated an order for amoxicillin (an antibiotic used to treat various bacterial infections) oral capsule 500 mg for one tablet by mouth three times a day for prophylaxis status post (s/p- essentially means after or following) tooth extraction. Resident 11`s care plans indicated that there was no care plan developed for Resident 11’s use of amoxicillin. The IPN explained that each time an antibiotic is ordered, a care plan must be developed to ensure the goal of treatment is identified and put in place interventions to monitor and prevent potential side effects or adverse effects of the antibiotic. During a review of the facility`s policy and procedure titled, Care Plans, Comprehensive Person-Centered, last reviewed on 6/25/2025, the policy indicated, &ldquo;A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident`s physical, psychosocial and functional needs is developed and implemented for each resident . assessments of residents are ongoing and care plans are revised as information about the residents and the resident`s condition changes.” 2. During a review of Resident 12’s admission Record, the admission Record indicated the facility admitted the resident on 6/2/2025 with diagnoses that included diabetes mellitus. During a review of Resident 12’s MDS dated [DATE], the MDS indicated Resident 12 was severely impaired in cognition with skills required for daily decision making. The MDS indicated Resident 12 was dependent on staff for personal hygiene. During a review of Resident 12’s physician orders, the physician orders indicated the following: - Humalog KwikPen (fast-acting insulin [a hormone that works by lowering levels of sugar in the blood]) subcutaneous (SQ - administering medication where a short needle is used to inject a medication into the tissue layer between the skin and the muscle) solution 100 units/milliliter (units/ml, used for insulin dosage and/or amount) inject as per sliding scale (progressive increase in the insulin dosage, based on pre-defined blood glucose ranges): If 70 – 150 milligrams/deciliter (mg/dL, a unit of measure for blood sugar), then give no units; If blood sugar is less than (<) 70 mg/dL, give orange juice then re-check after 15 minutes, notify the physician. If 151 – 200 mg/dL, then give 2 units; If 201 – 250 mg/dL, then give 4 units; If 251 – 300 mg/dL, then give 6 units; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	If 301 – 350 mg/dL, then give 8 units; If 351 – 400 mg/dL, then give 10 units; If 401 – 450 mg/dL, then give 12 units; for blood sugar 400 mg/dL and above, give dose, then notify physician, subcutaneously four times a day for DM, dated 6/02/2025. - Monitor blood sugar twice a day, inform the physician if the blood sugar is below 70 mg/dL or above 300 mg/dl (normal reference range is 70 – 100 mg/dL), for DM, dated 6/3/2025. During a review of Resident 12’s Care Plan for Diabetes, initiated 6/13/2025, the care plan indicated goals such as blood glucose levels will be within range as established by physician and will be free of signs or symptoms associated with hypoglycemia (low blood sugar) or hyperglycemia (high blood sugar). The care plan indicated interventions such as administer medications as ordered, blood glucose checks as ordered, report to the physician if blood glucose is outside of set parameters, and monitor for signs of hyper/hypoglycemia. During a review of Resident 12’s Medication Administration Record (MAR, a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for the month of 7/2025 and 8/2025, the MAR indicated the following: - For 7/2025, there were eight (8) instances of Resident 12’s blood sugar above 300 mg/dL. - For 8/2025, there were 10 instances of Resident 12’s blood sugar above 300 mg/dL. During an interview on 8/14/2025 at 2:14 p.m., with the Director of Nursing (DON), the DON stated Resident 12’s care plan for diabetes should have been implemented and followed for Resident 12’s elevated blood sugars. The DON stated it is important for Resident 12 to not have high blood sugars because of complications such as diabetic coma (life-threatening condition that occurs when blood sugar levels become dangerously high or low). During a review of the facility’s policy and procedure titled, “Care Plans, Comprehensive Person-Centered,” last reviewed 6/25/2025, the policy indicated the comprehensive, person-centered care plan includes measurable objectives and timeframes; includes the resident’s stated goals upon admission and desired outcomes; reflects currently recognized standards of practice for problem areas and conditions.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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 0684 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 observation, interview, and record review, the facility failed to ensure a qualified staff member adjusted the left extension knee splint (brace designed to help maintain or improve the range of motion at the knee joint) for one of three residents (Resident 105) with positioning and range of motion ([ROM] full movement potential of a joint) concerns in accordance with professional standards and the facility's job descriptions. This failure placed Resident 105 at an increased risk for developing injury, skin breakdown (tissue damage caused by friction [surfaces rubbing against each other], shear [strain produced by pressure], moisture, or pressure), and further ROM limitations on the left knee. Findings: During a review of Resident 105's admission Record, the admission Record indicated the facility admitted Resident 105 on 3/5/2025 and readmitted on [DATE] with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) following the cerebral infarction (brain damage due to a loss of oxygen to the area) affecting the left, non-dominant side, contracture (a stiffening/shortening at any joint that reduces the joint's range of motion) of the left hip and left knee, dysphagia (difficulty swallowing), and muscle weakness. During a review of Resident 105's Physical Therapy ([PT] profession aimed in the restoration, maintenance, and promotion of optimal physical function) Evaluation and Plan of Treatment, dated 3/5/2025, the PT Evaluation indicated Resident 105 had minimal loss of motion (approximately 75 percent [%] of full ROM) on the left hip and moderate loss of motion (approximately 50% of full ROM) on the left knee including a left knee contracture During a review of Resident 105's PT Discharge summary, dated [DATE], the PT Discharge Summary recommendations indicated for the Restorative Nursing Aide ([RNA] nursing aide program that helps residents to maintain their function and joint mobility) to provide Resident 105 with passive range of motion ([PROM] movement of a joint through the range of motion with no effort from person) to both legs and to apply both knee extension splints. During a review of Resident 105's physician's orders, dated 6/4/2025, the physician's orders indicated for RNA to provide PROM to both legs and to apply both knee extension splints for two to four hours (2-4 hours) or as tolerated, seven days per week. During a review of Resident 105's Change in Condition Evaluation (CICE), dated 7/12/2025, the CICE indicated Resident 105 was transferred to the General Acute Care Hospital (GACH) via emergency services due to a fever with shivering and increased heart rate. During a review of Resident 105's Census List, the Census List indicated the facility readmitted Resident 105 on 7/22/2025. During a review of Resident 105's PT Evaluation and Plan of Treatment, dated 7/22/2025, the PT Evaluation indicated Resident 105 had minimal loss of motion on the right knee, minimal loss of motion on the left hip, and severe loss of motion (approximately 25% or less of full ROM) on the left knee. During a review of Resident 105's Minimum Data Set ([MDS] a federally mandated resident assessment tool), dated 7/25/2025, the MDS indicated Resident 105 had clear speech, expressed ideas and wants, understood verbal content, and had moderately impaired cognition (ability to think, understand, learn, and remember). The MDS indicated Resident 105 required partial/moderate assistance (helper does less than half the effort) for eating and substantial/maximal assistance (helper does more than half the effort) for bathing and upper body dressing. The MDS indicated Resident 105 was dependent (helper does all the effort, resident does none of the effort to complete the activity, or the assistance of two or more helpers is required to complete the activity) for lower body dressing, rolling to both sides, transferring from lying to sitting on the side of the bed, chair/bed-to-chair transfers, and sit-to-stand transfers. During a review of Resident 105's PT Discharge summary, dated [DATE], the PT Discharge Summary recommendations included RNA for PROM exercises and application of both knee extension splints. During a review of Resident 105's physician's orders, dated 8/7/2025, the physician's order indicated for RNA to provide PROM to both legs and to apply both knee extension splints for 2-4 hours or as tolerated, seven days per week. During a concurrent observation and interview on 8/11/2025 at 9:51 a.m. in Resident 105's room, Resident 105 was lying in bed while watching television. Resident 105's left knee was observed in a bent position and was not wearing a knee splint. Resident 105 stated the facility staff (unidentified) did not apply the splint to the left knee. During an interview on 8/12/2025 at 9:49 a.m. with the Director of Rehabilitation (DOR 1), DOR 1 stated the purpose of splints (in general) included to prevent the development of contractures. During a concurrent observation and interview on 8/12/2025 at 10:49 a.m. with Resident 105 in the resident's room, Resident 105 was lying in bed and with both knees bent to approximately 90 degrees. Resident 105 did not have any splints applied to both knees. During a concurrent observation and interview on 8/13/2025 at 9:57 a

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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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. (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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide services to improve or maintain range of motion ([ROM] full movement potential of a joint) and mobility (ability to move) for three of four sampled residents (Resident 105, 55, and 56) with positioning, mobility, and restorative nursing ([RNA] nursing aide program that helps residents to maintain their function and joint mobility) concerns by failing to: 1. Objectively measure Resident 105's ROM in both legs during the Physical Therapy ([PT] profession aimed in the restoration, maintenance, and promotion of optimal physical function) Evaluations, dated 3/2/2025 and 7/22/2025. 2. Establish a treatment goal to improve Resident 105's left knee ROM after experiencing a decline from moderate ROM limitations (reflecting approximately 50 percent [%] of full ROM) to severe ROM limitations (reflecting 25% or less of full ROM) during the PT Evaluation, dated 7/22/2025. 3. Apply Resident 105's left resting hand splint (brace secured with straps that extends from the fingers to the forearm to properly position the fingers and wrist), left elbow extension splint (brace designed to help maintain or improve the range of motion at the elbow joint, specifically focusing on the ability to straighten or extend the arm), and both knee extension splints (brace designed to help maintain or improve the range of motion at the knee joint) on 8/12/2025 in accordance with the physician's orders, dated 8/7/2025.4. Apply Resident 55's left pressure relief ankle foot orthoses ([PRAFO] device worn on the calf and foot to suspend the heel and hold the ankle in neutral [90 degree] position) from 6/12/2025 to 6/16/2025 when transitioning from PT to RNA services. 5. Apply both of Resident 55's knee extension splints on 8/12/2025 and 8/13/2025 in accordance with the physician's order, dated 5/17/2025. 6. Apply Resident 55's left PRAFO on 8/12/2025 and 8/13/2025 in accordance with the physician's order, dated 6/17/2025. 7. Provide ambulation assistance to Resident 56 from 6/14/2025 to 6/16/2025 when transitioning from PT to RNA services. These failures had the potential for Resident 105 and 55 to experience further decline in ROM and for Resident 56 to experience a decline in the ability to walk. Findings: a. During a review of Resident 105's admission Record, the admission Record indicated the facility admitted Resident 105 on 3/5/2025 and readmitted on [DATE] with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) following the cerebral infarction (brain damage due to a loss of oxygen to the area) affecting the left, non-dominant side, contracture (a stiffening/shortening at any joint that reduces the joint's range of motion) of the left hip and left knee, dysphagia (difficulty swallowing), and muscle weakness. During a review of Resident 105's Occupational Therapy ([OT] profession aimed to increase or maintain a person's capability of participating in everyday life activities [occupations]) Evaluation and Plan of Treatment, dated 3/5/2025, the OT Evaluation indicated Resident 105's ROM in the right arm was within functional limits ([WFL] sufficient joint movement without significant limitation) and had limited active range of motion ([AROM] performance of an exercise to move a joint without any assistance or effort of another person) in the right shoulder. The OT Evaluation indicated Resident 105 had severe loss of motion (approximately 25% or less of full ROM) in the left shoulder, measuring 0-30 degrees (unit of joint measurement, normal 0-180 degrees), due to pain and muscle tightness, but had WFL ROM in the left elbow, forearm, wrist, and hand. During a review of Resident 105's PT Evaluation and Plan of Treatment, dated 3/5/2025, the PT Evaluation indicated Resident 105 had minimal loss of motion (approximately 75% of full ROM) on the left hip and moderate loss of motion (approximately 50% of full ROM) on the left knee which had a contracture. The PT Evaluation did not include measurements of the left hip and knee. During a review of Resident 105's OT Discharge summary, dated [DATE], the OT Discharge Summary indicated Resident 105 tolerated the left resting hand splint and the left elbow extension splint for two-and-a half (2.5) hours. The OT Discharge Summary did not include the RNA Program. During a review of Resident 105's PT Discharge summary, dated [DATE], the PT Discharge Summary recommendations indicated for the RNA to provide Resident 105 with passive range of motion ([PROM] movement of a joint through the range of motion with no effort from person) to both legs and to apply both knee extension splints. During a review of Resident 105's physician's orders, dated 6/4/2025, the physician's orders indicated for RNA to provide PROM to both arms and legs, to apply the left resting hand splint for 2-3 hours or as tolerated, to apply the left elbow extension splint for 2-3 hours or as tolerated, and to apply both knee extension splints for 2-4 hours or as tolerated, seven days per week. During a review of Resident 105's Change in Condition Evaluation (CICE), dated 7/12/2025, the CICE indicated Resident 105 was transferred to the General Acute Care Hospital (GACH) via emergency services due to a fever with

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West Valley Post Acute	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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the urinary catheter tubing (a hollow tube inserted into the bladder to drain or collect urine) was positioned free flowing, without dependent loops (a sagging or U shaped section of the drainage tubing that dips below the level of the drainage bag) or kinks (twist) and did not backflow to the urine drainage port (a component of a urinary catheter that allows urine to flow from the bladder into the collection bag) for two of two sampled residents reviewed under the urinary catheter care area (Resident 44 and Resident 15).This deficient practice had the potential to negatively affect Resident 44 and Resident 15 from receiving the proper care necessary to prevent UTI's (urinary tract infection - an infection in the bladder/urinary tract).Findings: a. During a review of Resident 44’s admission Record, the admission Record (front page of the chart that contains a summary of basic information about the resident) indicated the facility admitted Resident 44 initially on 7/20/2022 and readmitted on [DATE] with diagnoses including Alzheimer’s disease (a disease characterized by a progressive decline in mental abilities), aphasia (a disorder that makes it difficult to speak) and neuromuscular disfunction of the bladder (nerve damage that causes the inability to control urination normally). During a review of Resident 44’s Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 5/20/2025, the MDS indicated Resident 44 usually understood others and was usually able to make herself understood. The MDS indicated Resident 44 was dependent on facility staff for all activities of daily living (ADLs - activities such as bathing, dressing and toileting a person performs daily) and had a urinary catheter. During an observation on 8/13/2025 at 10:28 am in Resident 44’s room, Resident 44 was lying in bed with a urinary catheter bag hanging on the left side of the resident’s bed frame. The urinary catheter tubing hung below the right side of the bed and had a large, dependent loop. The looped portion of the urinary catheter tubing contained yellow liquid with a small amount of sediment that back flowed towards the urine drainage port. During a concurrent observation and interview on 8/13/2025 at 10:32 am with Certified Nurse Assistant (CNA 6) in Resident 44’s room, CNA 6 stated Resident 44’s urinary catheter tubing was looped and contained yellow liquid with white sediment that back flowed toward the urine drainage port. CNA 6 stated the urinary catheter tubing should be straight to drain the urine into the urinary catheter bag. CNA 3 further stated if the urine is not draining properly, the Resident 44 could possibly get an infection because the urine might backflow into his body. During an interview on 8/14/2025 at 1:36 pm with the Director of Nursing (DON), the DON stated staff should always ensure urinary catheter tubing remain straight and not coiled or looped to prevent UTI’s. The DON further stated Resident 44 has a history of UTI’s and it is necessary to prevent urine back flow. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) titled, “Catheter Care, Urinary,” last reviewed on 6/25/2025, the P&P indicated to maintain unobstructed urine flow and to check the resident frequently to be sure he or she is not lying on the catheter and to keep the catheter and tubbing free of kinks. b. During a review of Resident 15’s admission Record the admission Record indicated the facility originally admitted Resident 15 on 2/8/2025 and re-admitted Resident 15 on 7/12/2025, with diagnoses including hypertension (high blood pressure), hyperlipidemia (high concentration of fats in the blood), depression, neuromuscular dysfunction of the bladder and urinary tract infection. During a review of Resident 15’s History and Physical (H&P), dated 7/14/2025, the H&P indicated Resident 15 had the capacity to understand and make decisions. During a concurrent interview and observation on 8/12/2025 at 2:40 p.m. in Resident 15’s room with Licensed Vocational Nurse (LVN) 1, LVN 1 stated that Resident 15’s urinary catheter tubbing had a dependent loop and urine was noted on the dependent loop. LVN 1 stated that urine was not able to drain into the urine collection bag because the tubbing was not straight. LVN 1 stated that dependent loops or kinks on the tubbing could cause urine not to drain properly and could potentially cause the urine to backflow into the resident. LVN 1 stated that proper placement of a foley catheter tubbing, and urine bag should be maintained below the resident, straight and free flowing without any obstructions. LVN 1 stated that urine will not be seen in the tubing when free flow occurs into the urine bag. LVN 1 stated that not following proper urinary catheter tubing placement can potentially lead to urinary tract infections or prevent the healing of the urinary tract infections. During an interview on 8/13/2025 at 11:28 a.m. with Registered Nurse (RN) 1, RN 1 stated that it is important for the urinary catheter tubing to be straight without any dependent loops or kinks. RN 1 stated that maintaining a straight position for the tubing allows the urine to flow into the urine collection bag and prevents the urine from flowing back into Resident 15. RN 2 stated that if urine back flows into Resident 15, this can potentially lead to urinary tract infections and pain or prevent an existing urinary tract infection from clearing up. During an interview on 8/14/2025 at 1:55 p.m. with the Director of Nursing (DON), the DON stated that the urinary catheter tubing needs to be below the bladder and free flowing without any dependent loops or kinks. The DON stated that if the urinary catheter tubbing is not straight and with dependent loops or kinks it can cause urinary tract infections, complicate an existing urinary tract infection or cause pain. The DON stated that these complications can lead to other serious health problems involving kidney damage for any resident with a urinary catheter in place. During a review of the facility’s policy and procedure (P&P) titled “Catheter Care, Urinary. ” dated 7/2025, the P&P indicated, “Maintaining Unobstructed Urine Flow: 1. Check the resident frequently to be sure he or she is not lying on the catheter and to keep the catheter and tubbing free of kinks.”

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to provide nutritional care and services consistent with the resident's nutritional assessment and care plan for one of three sampled residents (Resident 8) reviewed under the nutritional care area by: 1. Failing to obtain the resident's weight on readmission from the General Acute Care Hospital (GACH, or simply hospital).2. Failing to obtain weekly weights This deficient practice had the potential to result in further weight loss for Resident 8 after their return from the GACH on 7/23/2025. Findings: During a review of Resident 8's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that included stroke, protein-calorie malnutrition (a form of malnutrition that occurs when the body does not get enough protein and calories from food) and end stage renal disease (when kidneys no longer function well enough to meet a body's needs). During a review of Resident 8's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 7/26/2025, the MDS indicated Resident 8 was severely 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 Resident 8 required partial or moderate assistance (helper does less than half the effort) with eating. The MDS indicated Resident 8 had a loss of 5% or more in the last month or loss of 10% or more in the last six months. The MDS indicated Resident 8 was not in a physician-prescribed weight-loss regimen. During a review of Resident 8's Nursing Progress Notes, the progress notes indicated the following:- 7/19/2025 Received a call from resident's spouse informing staff that resident was transferred to a GACH from the dialysis center due to continuous vomiting. - 7/23/2025 Licensed nurses re-admitted Resident 8 from the GACH During a review of Resident 8's Physician's Orders, the Physician's Orders indicated the following: - Renal diet, mechanical soft texture (pudding like texture), thin liquids consistency (regular water without any thickener added), dated 7/23/2025. - Dialysis Center, Tuesday, Thursdays, Saturdays, chair time: (time when a resident starts their dialysis treatment), dated 7/24/2025. - Prostat (a protein liquid supplement) 30 milliliters (ml, metric unit of measurement, used for medication dosage and/or amount) two times a day as a dietary supplement, may mix with water or juice, dated 7/31/2025. During a review of Resident 8's Interdisciplinary Team (IDT, a group of disciplines, such as nursing, dietary, and social services who meet to help a resident in their medical plan of care) Weight Variance (a meeting in which the IDT meets to discuss goals and interventions to prevent weight loss in residents) Assessment, effective date, 8/01/2025 and entered into the electronic medical record 8/14/2025, the assessment indicated the problem was there was a weight loss of 10.75% in three weeks. The assessment indicated an intervention that there would be weight taken weekly for four weeks upon admission and then monthly if stable. During a review of Resident 8's Care Plan for Altered Nutrition, initiated 7/24/2025, the care plan indicated a goal that Resident 8 will not have significant weight loss to the extent possible. The care plan indicated an intervention to take weekly weights for four weeks upon admission and then monthly if stable. During a review of Resident 8's Weights, it indicated the following: - 7/05/2025 156.2 pounds (lbs., a unit of measure for weight) post dialysis weight (weight taken after the completion of dialysis) - 7/26/2025 139.4 lbs. post dialysis weight - 7/31/2025 140.8 lbs. post dialysis weight - No other weights from the survey period 8/11/2025 through 8/14/2025 During a review of Resident 8's Nursing Progress Notes, dated 7/31/2025, the notes indicated the dialysis' registered dietician, RD 2 ordered Prostat twice a day and to increase protein intake during breakfast. The progress note indicated orders were noted and carried out. During a concurrent interview and record review with the Minimum Data Set Coordinator (MDSC) on 8/13/2025 at 2:24 p.m., reviewed Resident 8's Weights. When asked why Resident 8 was not weighed upon admission on [DATE] when Resident 8 returned from the hospital, the MDSC stated, per the Assistant Director of Nurses (ADON), dialysis residents' weights are taken by the dialysis center after dialysis has been completed for that visit. When asked why licensed nurses waited three days to find out Resident 8 had weight loss, the MDSC did not have an answer. During an interview with the ADON on 8/14/2025 at 7:46 a.m. , she stated residents' weights are usually taken within 24 hours unless they refuse to have them done. During an interview on 8/14/2025 at 7:49 a.m., with Restorative Nursing Assistant 3 (RNA 3), he stated the restorative nursing assistants do not weigh dialysis residents. RNA 3 stated the ADON instructed them not to weigh them because the licensed nurses use the dialysis center's post dialysis weights. During a concurrent interview and record review with the MDSC on 8/14/2025 at 8:08 a.m., reviewed Resident 8's Weight

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to: 1. Account for one (1) dose of Controlled Substances (also known as Controlled Drug and Controlled Medications [CS, CD, CM]- medications which have a potential for abuse and may also lead to physical or psychological dependence) for Resident 2 in one (1) of two (2) inspected medication carts (Medication Cart 3.) 2. Account for one (1) dose of CS for Resident 102 in one (1) of two (2) inspected medication carts (Medication Cart 2.) 3. Reconcile (the process of comparing transactions and activity to supporting documentation) and account for four (4) medication emergency kits (eKITs) containing CSs for August 2025, in one (1) of one (1) inspected Medication Rooms (Medication room [ROOM NUMBER].) As a result, control and accountability of CSs did not follow state and federal regulations and facility policy and procedures. 4. Replace one (1) open and used eKIT containing antibiotics within 72 hours of opening the kit in one (1) of one (1) inspected Medication Rooms (Medication room [ROOM NUMBER].) 5. Remove from use one (1) expired insulin (a medication used to regular blood sugar levels) Solostar (type of injection device) pen for Resident 11 from one (1) of two (2) inspected medications carts (Medication Cart 3.) 6. Remove from use one (1) expired umeclidinium (a medication used to treat chronic obstructive pulmonary disease [COPD - a disease causing shortness of breath]) oral inhalation powder for Resident 49 from Medication Cart 4, observed during Medication Administration Task. 7. Have umeclidinium oral inhalation powder for Resident 49 available in Medication Cart 4 for use, observed during Medication Administration Task. 8. Have liraglutide (a medication used to manage blood sugar levels) injection for Resident 99 available in Medication Cart 2 for use, observed during Medication Administration Task. These deficient practices increased the opportunity for CS diversion (the transfer of a controlled medication or other medication from a lawful to an unlawful channel of distribution or use,) and the risk that Resident 2 and 102 could experience adverse drug reactions [unwanted, uncomfortable, or dangerous effects that a medication may have, such as coma (a state of deep unconsciousness) from exposure to harmful medications, residents in the facility could have delayed medication treatment from unavailability of emergency use medications, and for Resident 11, 49 and 99 to experience health complications such as breathing difficulty, high or uncontrolled blood sugar levels, diabetic coma (a life-threatening complication that can result from very high blood sugar or very low blood sugar levels,) all leading to physical and psychosocial harm, hospitalization and/or death. Findings: During an observation on 8/11/2025 at 9:30 a.m., in Medication Cart Station 2, Licensed Vocational Nurse (LVN) 1 was observed administering several medications orally to Resident 99. Resident 99 was observed swallowing the medications with glass of water. LVN 1 was not observed administering liraglutide subcutaneous ([SQ] - under the skin) injection to Resident 99. During an interview on 8/11/2025 at 11:49 a.m., with LVN 1, LVN 1 stated LVN 1 administered several medications orally to Resident 99 and did not administer liraglutide that day (8/11/2025) at 9:30 a.m. to Resident 99, as prescribed by Resident 99's physician, since liraglutide injection was not available in Medication Cart 2. LVN 1 stated that medications should be readily available to ensure timely administration at the scheduled times. LVN 1 stated liraglutide was a medication used to regulate blood sugar levels and not administering and missing a dose could harm Resident 99 by not controlling blood sugar levels causing hyperglycemia (high blood sugar level) and Diabetic Ketoacidosis ([DKA] - serious complication of high blood sugar level that can be life-threatening and requires immediate medical attention) leading to hospitalization. LVN 1 stated facility failed to ensure liraglutide injection was readily available in Medication Cart 2 at time of scheduled dose, resulting in Resident 99 not receiving a dose one (1) hour before to one (1) hour after the 9 a.m. scheduled dose. During a review of Resident 99's admission Record dated 8/11/2025 the admission Record indicated Resident 99 was originally admitted to the facility on [DATE] with diagnosis including Type 2 Diabetes Mellitus ([DM2]- a condition that affects how the body processes blood sugar.) During a review of Resident 99's Order Summary Report dated 8/11/2025, the report indicated Resident 99 was prescribed:1. Liraglutide to inject 1.8 milligram ([mg] - a unit of measure of mass) SQ once a day for DM 2, starting 7/11/2025.During a review of Resident 99's MAR for August 2025, the MAR indicated Resident 99 was prescribed:1. Liraglutide to inject 1.8 mg SQ once a day for DM 2, at 9 a.m. During an observation on 8/11/2025 at 1:08 p. m., with Registered Nurse (RN) 2, in Medication Cart 3, there was a discrepancy in the count between the Medication Count Sheet accountability log (an inventory and accountability form for CSs) and the amount of medication remaining in the medication bubble pack (medication packaging system that contains individual

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on interview and record review, the facility failed to ensure the Medication Regimen Review (MRR - review of a resident's drug therapy to assure appropriateness of medication usage completed each month by the consultant pharmacist) was acted upon for one (Resident 12) of six residents investigated for unnecessary medications, by failing to act upon the facility consultant pharmacist's recommendation to provide a location of application for Diclofenac Gel (a nonsteroidal anti-inflammatory drug [NSAID] used topically for pain relief and inflammation).This had the potential for licensed nurses not to know the location of Resident 12's pain.Findings:During a review of Resident 12's admission Record, the admission Record indicated the facility admitted the resident the facility on 6/02/2025 with diagnoses including diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing) and contact dermatitis (a skin condition caused by direct contact with an irritant or allergen, resulting in rash and inflammation). During a review of Resident 12's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 6/12/2025, the MDS indicated Resident 12 was severely 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 Resident 12 was dependent on staff for personal hygiene. During a review of Resident 12's Physician's Orders, the Physician Order indicated an order for Diclofenac Sodium External Gel 1%, apply to affected area topically every six hours as needed for pain, dated 6/02/2025.During a review of Resident 12's Consultant Pharmacist's MRR, created between 7/01/2025 and 7/07/2025, the MRR indicated Resident 12's physician to provide the location the Diclofenac Gel is to be applied to. During a concurrent interview and record review with the Minimum Data Set Coordinator (MDSC) on 8/13/2025 at 2:24 p.m., reviewed Resident 12's MRR for the month of 7/2025. The MRR recommended that Resident 12's physician provide a location for application of the Diclofenac Gel. The MDSC stated the licensed nurses need to speak to Resident 12's physician to clarify the order to add a location. The MDSC stated this was important to see if Resident 12's pain management is effective. The MDSC stated the Diclofenac could possibly be an unnecessary medication if not clarified.During an interview with the Director of Nursing (DON) on 8/14/2025 at 2:16 p.m., the DON stated the Diclofenac order needs to be clarified with Resident 12's physician to obtain the specific location of the medication application. The DON stated it is important to know where Resident 12's pain is located.During a review of the facility's policy and procedure titled, Drug Regimen Review, last reviewed 6/25/2025, indicated the following:- Findings and recommendations by the Consultant pharmacist are reported to the Administrator, Director of Nursing, the responsible physician, and the Medical Director, where appropriate.- The Consultant pharmacist documents all potential or actual significant nursing documentation problems found relating to medications and communicates them in writing to the Director of Nursing, within five working days of the review.- Drug Regimen Review recommendations to physician-o A copy of the report is kept by the facility until the physician's signed response is returnedo The physician response is provided to the Consultant pharmacist for review and then filed by the facility.- Nursing Documentation Reviewo The Consult pharmacist provides the report within five working days of review.o Nursing personnel provide a written response to the review within two weeks after the report is receivedo A copy of the report is kept by the facility until the nurse's response is returned.o Nursing staff response to the report is provided to the Consultant pharmacist for review and then filed by the facility.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that its medication error rate was less than five (5) percent (%). Four (4) medication errors out of 28 total opportunities contributed to an overall medication error rate of 14.29% affecting three (3) of four (4) residents observed for medication administration (Resident 4, 49 and 99.) The medication errors were as follows:1. Resident 4 did not receive polyethylene glycol (a medication used for bowel management) as ordered by Resident 4's physician. 2. Resident 49 received Spiriva (a medication used to treat chronic obstructive pulmonary disease [COPD - a disease causing shortness of breath) at a different dose than ordered by Resident 49's physician. 3. Resident 49 was to be administered expired umeclidinium (a medication used to treat COPD) oral inhalation powder. 4. Resident 99 did not receive liraglutide (a medication used to manage blood sugar levels,]) injection as ordered by Resident 99's physician. These failures had the potential to result in Resident 4, 49 and 99 to experience medication adverse effects (unwanted, uncomfortable, or dangerous effects that a medication may have,) and health complications such as constipation, uncontrolled blood sugar levels, difficulty breathing, resulting in Resident 4's, 49's and 99's health and well-being to be negatively impacted. Findings:During an observation on 8/11/2025 at 9:30 a.m., in Medication Cart Station 2, Licensed Vocational Nurse (LVN) 1 was observed administering several medications orally to Resident 99. Resident 99 was observed swallowing the medications with glass of water. LVN 1 was not observed administering liraglutide subcutaneous ([SQ] - under the skin) injection to Resident 99. During an interview on 8/11/2025 at 11:49 a.m. , with LVN 1, LVN 1 stated LVN 1 administered several medications orally to Resident 99, and did not administer liraglutide that day (8/11/2025) at 9:30 a.m. to Resident 99, as prescribed by Resident 99's physician, since liraglutide injection was not available in Medication Cart 2. LVN 1 stated this was considered a significant medication error. LVN 1 stated that medications should be readily available to ensure timely administration at the scheduled times. LVN 1 stated liraglutide was a medication used to regulate blood sugar levels and not administering and missing a dose could harm Resident 99 by not controlling blood sugar levels causing hyperglycemia (high blood sugar level) and Diabetic Ketoacidosis ([DKA] - serious complication of high blood sugar level that can be life-threatening and requires immediate medical attention) leading to hospitalization. LVN 1 stated facility failed to ensure liraglutide injection was readily available in Medication Cart 2 at time of scheduled dose, resulting in Resident 99 not receiving a dose one (1) hour before to one (1) hour after the 9 a.m. scheduled dose. During an observation on 8/11/2025 at 10:10 a.m., in Medication Cart Station 2, LVN 1 was observed administering several medications orally to Resident 4. Resident 4 was observed swallowing the medications with glass of water. LVN 1 was not observed administering polyethylene glycol to Resident 4. During an interview on 8/11/2025 at 11:49 a.m., with LVN 1, LVN 1 stated LVN 1 administered several medications orally that day (8/11/2025) at 10:10 a.m. to Resident 4 and failed to prepare and administer polyethylene glycol. LVN 1 acknowledged the physician's order specified to administer polyethylene glycol at 9 a.m. LVN 1 stated per facility policy, there was a 60-minute window before and after the scheduled time for medication administration. LVN 1 stated polyethylene glycol was a laxative and not administering could potentially harm Resident 4 by causing constipation. LVN 1 stated that LVN 1 failed to follow five (5) rights of medication administration and failed to administer polyethylene glycol to Resident 4 at 9 a.m., as prescribed by the physician. LVN 1 stated this was considered a medication error. During an observation on 8/12/2025 at 9:41 a.m., in Medication Cart Station 4, LVN 3 was observed handing Resident 49 Spiriva oral inhalation that LVN 3 had prepared for administration. Resident 49 was observed to be orally inhaling two (2) puffs of Spiriva. During an interview, on 8/12/2025 at 9:42 a.m., with LVN 3, LVN 3 stated Resident 49 orally inhaled two (2) puffs of Spiriva. LVN 3 acknowledged the physician's order specified to administer one (1) oral puff of Spiriva. LVN 3 stated the wrong dose of Spiriva was administered to Resident 49. LVN 3 stated LVN 3 failed to follow the five (5) rights of medication administration by administering the wrong dose of Spiriva and failing to instruct Resident 49 to stop inhaling after one (1) oral puff. LVN 3 stated this was considered a medication error and administering additional dose of Spiriva increased the risk of Resident 49 to experience medication adverse effects. During an observation on 8/12/2025 at 10:10 a.m., in Medication Cart Station 4, LVN 3 was observed handing Resident 49 umeclidinium inhalation device that LVN 3 had prepared for administration. LVN 3 was stopped by the surveyor before umeclidinium was administered to Resident 49 and advised to discuss the medication

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West Valley Post Acute	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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. (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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were free of any significant medication errors (means the observed or identified preparation or administration of medications or biologicals which is not in accordance with the prescriber's order, manufacturer's specifications, and accepted professional standards) by: 1. administering three (3) doses of expired Umeclidinium-Vilanterol (a medication used for chronic obstructive pulmonary disease [COPD - a disease causing shortness of breath)]) Ellipa (medication delivery device) inhalation powder by Licensed Vocational Nurse (LVN) 7 and Registered Nurse (RN) 2 between 8/9/2025 and 8/11/2025 to Resident 63 in one (1) of two (2) inspected medication carts (Medication Cart 3,) not in accordance with standards of practice. This deficient practice had the potential to cause Resident 63 to experience serious complications such as shortness of breath, difficulty breathing, and exacerbation (worsening) of COPD, resulting in potential hospitalization. Findings: During an observation on 8/11/2025 at 1:08 p.m., with RN 2, in Medication Cart 3, the following medications were found either stored in a manner contrary to their respective manufacturers' requirements, not labeled with an open date as required by their respective manufacturers' specifications, expired and not discarded, or stored and labeled contrary to facility policies, currently accepted laws and professional principles: 1. One (1) open Umeclidinium-Vilanterol Ellipta inhalation powder for Resident 63 was found stored at room temperature and labeled with a date indicating use began on 6/27/2025. According to the manufacturer's product labeling, Umeclidinium-Vilanterol Ellipta inhalation powder should be discarded six (6) weeks after opening the foil pouch (package made of foil protecting the device from light and degradation) or when the counter reads 0, whichever comes first. During a concurrent interview, RN 2 stated that the Umeclidinium-Vilanterol Ellipta inhalation powder for Resident 63 was stored in Medication Cart 3 and opened on 6/27/2025. RN 2 stated according to the manufacturer guidelines printed on the carton box containing the Umeclidinium-Vilanterol Ellipta inhalation powder, to store the inhaler at 68 and 77 degrees Fahrenheit and discard the inhaler 6 weeks after opening the foil pouch or when the counter reads 0, whichever comes first. RN 2 stated the inhalation powder expired on 8/8/2025 and needed to be removed the medication cart to prevent usage in error. RN 2 stated expired Umeclidinium-Vilanterol Ellipta inhalation powder has lost potency (strength) and will not be effective in treating the COPD potentially causing harm to resident 63 exacerbating the shortness of breath associated with COPD leading to difficulty in breathing and resulting in potential hospitalization. RN 2 stated several licensed nurses failed to remove expired Umeclidinium-Vilanterol Ellipta inhalation powder from Medication Cart 3 and as a result, several licensed nurses including RN 2 administered three (3) doses of expired Umeclidinium-Vilanterol Ellipta inhalation powder to Resident 63 between 8/9/2025 and 8/11/2025. During an interview on 8/12/2025 at 2:37 p.m., with the Director of Nursing (DON), the DON stated that the facility failed to dispose of expired Umeclidinium-Vilanterol Ellipta inhalation powder for Resident 63, and as a result Licensed Vocational Nurse (LVN) 7 and RN 2 failed not to administer expired Umeclidinium-Vilanterol Ellipta inhalation powder to Resident 63. The DON stated expired Umeclidinium-Vilanterol Ellipta inhalation powder has lost potency and will not be effective in treating Resident 63's COPD leading to difficulty in breathing, exacerbation of COPD and potential hospitalization. The DON stated per facility policy, expired medications needed to be removed from use to prevent accidental administrations, and five (5) rights of medication administration followed. The DON stated these were considered medication errors, and that LVN 7 and RN 2 failed to follow facility medication administration guidelines. During a review of Resident 63's admission Record (a document containing demographic and diagnostic information,) dated 8/11/2025, the admission Record indicated Resident 63 was originally admitted to the facility on [DATE] with diagnoses including COPD. During a review of Resident 63's Order Summary Report, dated 8/11/2025, the report indicated Resident 63 was prescribed Umeclidinium-Vilanterol inhalation powder to take one (1) puff inhale orally once a day for COPD, starting 12/5/2024. During a review of Resident 63's MAR ([MAR] - a document of the medications administered to a resident that is part of the resident's permanent medical record] for August 2025, the MAR indicated Resident 63 was prescribed Umeclidinium-Vilanterol inhalation powder to take one (1) puff inhale orally once a day for COPD, at 9 a.m., and that Resident 63 received the following doses by the following licensed nurses: LVN 7 - two (2) doses on (8/9/2025, 8/10/2025) at 9 a.m.RN 2 - one (1) dose on 8/11/2025 at 9 a.m During a review of the facility's policy and procedures (P&P) titled Administering Medications, last reviewed

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview, and record review the facility failed to remove and discard from use: 1. one (1) open, expired insulin (a medication used to control high blood sugar levels) Lantus (brand name insulin for glargine, a long-acting insulin) Solostar (a type of insulin injection device) pen stored at room temperature for Resident 11, in accordance with manufacturer's requirements and facility policy and procedures, in one (1) of two (2) inspected medications carts (Medication cart 3.) 2. one (1) open, expired Umeclidinium-Vilanterol (a medication used for chronic obstructive pulmonary disease [COPD - a disease-causing shortness of breath)]) Ellipa (medication delivery device) inhalation powder for Resident 63, in accordance with facility policy and procedures and manufacturer's requirements, in one (1) of two (2) inspected medications carts (Medication Cart 3.) These deficient practices increased the risk for Resident 11 to receive insulin that was compromised (decreased) in efficacy and potency (strength of a medication,) for treating Resident 11's blood sugar levels, potentially resulting in high or uncontrolled blood sugar levels, and diabetic coma (a life-threatening complication that can result from very high blood sugar or very low blood sugar levels;) and in Resident 63 receiving medication that was compromised in efficacy and potency for treating Resident 63's COPD, potentially resulting in health complications such as shortness of breath, difficulty in breathing, COPD exacerbation, all of which could lead to harm, hospitalization and/or death. Findings: During an observation on 8/11/2025 at 1:08 p.m., with Registered Nurse (RN) 2, in Medication Cart 3, the following medications were found either stored in a manner contrary to their respective manufacturers' requirements, not labeled with an open date as required by their respective manufacturers' specifications, expired and not discarded, or stored and labeled contrary to facility policies, currently accepted laws and professional principles:1. One (1) open Lantus Solostar pen for Resident 11 was found stored at room temperature and labeled with a date indicating use began on 6/25/2025. According to the manufacturer's product labeling, opened Lantus Solostar pens should be stored at room temperature up to 86 degrees Fahrenheit and used or discarded within 28 days of opening or once storage at room temperature began. 2. One (1) open Umeclidinium-Vilanterol Ellipta inhalation powder for Resident 63 was found stored at room temperature and labeled with a date indicating use began on 6/27/2025. According to the manufacturer's product labeling, Umeclidinium-Vilanterol Ellipta inhalation powder should be discarded six (6) weeks after opening the foil pouch (package made of foil protecting the device from light and degradation) or when the counter reads 0, whichever comes first. During a concurrent interview, RN 2 stated the Lantus Solostar pen for Resident 11 was opened on 6/25/2025. RN 2 stated insulins are usually good for 28 days and lose potency (effectiveness) and expire beyond that date. RN 2 stated the Lantus Solostar pen expired on 7/23/2025. RN 2 stated the Lantus Solostar pen needed to be removed from the Medication Cart 3 and discarded to ensure expired insulin was not administered to Resident 11. RN 2 stated administering expired insulin will not be effective in treating residents blood sugar levels and can harm Resident 11 by causing high blood sugar levels leading to coma (a life-threatening complication that can result from very high blood sugar or very low blood sugar levels,) hospitalization, and death. During the same interview, RN 2 stated that the Umeclidinium-Vilanterol Ellipta inhalation powder for Resident 63 was stored in Medication Cart 3 and opened on 6/27/2025. RN 2 stated according to the manufacturer guidelines printed on the carton box containing the Umeclidinium-Vilanterol Ellipta inhalation powder, to store the inhaler at 68 and 77 degrees Fahrenheit and discard the inhaler 6 weeks after opening the foil pouch or when the counter reads 0, whichever comes first. RN 2 stated the inhalation powder expired on 8/8/2025 and needed to be removed from the medication cart to prevent usage in error. RN 2 stated expired Umeclidinium-Vilanterol Ellipta inhalation powder has lost potency (strength) and will not be effective in treating the COPD potentially causing harm to resident 63 exacerbating the shortness of breath associated with COPD leading to difficulty in breathing and resulting in potential hospitalization. RN 2 stated several licensed nurses failed to remove expired Umeclidinium-Vilanterol Ellipta inhalation powder from Medication Cart 3 and as a result, several licensed nurses including RN 2 administered three (3) doses of expired Umeclidinium-Vilanterol Ellipta inhalation powder to Resident 63 between 8/9/2025 and 8/11/2025. During an interview on 8/12/2025 at 2:37 p.m., with the Director of Nursing (DON), the DON stated that the facility failed to dispose of expired Umeclidinium-Vilanterol Ellipta inhalation powder for Resident 63, and as a result, Licensed Vocational Nurse (LVN) 7 and RN 2 failed not to administer expired Umeclidinium-Vilanterol Ellipta inhalation powder to Resident 63. The DON stated expired Umeclidinium-Vilanterol Ellipta inhalation powder has lost potency and

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West Valley Post Acute	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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, and record review, the facility failed to follow the menu and did not meet nutritional needs of residents when:a. [NAME] 1 used perforated spoon (a large spoon with slots or holes for draining liquids) when portioning carrots and broccoli.b. [NAME] 2 mashed the sweet potato fries in the number 8 scoops (1/2 cup, [c, household measurement) to fill it in causing more than 1/2 c of sweet potato fries per serving. This failure had the potential to decrease nutrient and fiber intake and increase nutrient intake of calories and carbohydrates resulting in unplanned weight loss, unplanned weight gain and ineffective diet therapy to 74 of 101 residents on regular texture (texture of food with no restrictions and modifications) diet and consistent carbohydrate (CCHO, diet consisting of the same amount of carbohydrate each meal), getting food from the kitchen. Findings:a. During a review of the facilities' daily spreadsheet (a list of food, amount of food that each diet would receive) titled Summer Menus, dated 8/11/2025, the spreadsheet indicated residents on regular texture diet would include sweet potato fries 1/2 c. During an observation on 8/11/2025 at 12:08 p.m. of trayline (an area where foods were assembled from the steamtable to resident's plate) lunch service, observed [NAME] 1 used perforated spoon when portioning diced carrots. During an observation on 8/11/2025 at 12:16 p.m. of the trayline lunch service, observed [NAME] 1 used perforated spoon when portioning diced carrots and broccoli. During an interview on 8/11/2025 at 1:07 p.m. with the Dietary Supervisor (DS), the DS stated the perforated spoon was not an approved utensil to portion foods and it is only used for cooking and stirring food. The DS stated vegetables (carrots and broccoli) were 1/2 c portions and if a perforated spoon was used to portion vegetables, then [NAME] 1 did not use the right scoop. The DS stated [NAME] 1 should have used a perforated spoodle (a kitchen utensil that combines the features of spoon and ladle used for serving and portioning food). The DS stated not using the right utensils means not serving the right portion or less vegetables were served to the residents. The DS stated the residents would not get the nutrients they need and could potentially cause them to lose weight. b. During an observation on 8/11/2025 at 12:29 p.m. of trayline lunch service, [NAME] 2 overfilled the number 8 scoop with sweet potato fries by mashing them in. During an interview on 8/11/2025 at 1:21 p.m. with the DS, the DS stated the sweet potato fries was 1/2 c. a portion, but it was hard to portion. The DS stated [NAME] 2 should have not smashed the sweet potato fries using his hand in the number 8 scoop to fill it in because it would exceed the portion size indicated in the spreadsheet. The DS stated residents could have unintentional weight gain if they received more portions of sweet potato fries. During a review of the facility's policies and procedures (P&P) titled Portion Control dated 5/28/2025, the P&P indicated, To provide specific portion control information. Procedure: To be sure portions served is equal portion sizes listed on the menu, portion control equipment must be used. A variety of portion control equipment should be available and utilized by employees portioning food. (1) Scoops are sized by number (the number of scoopfuls needed to equal one quart). The smaller the number, the larger the size. Scoop numbers and amounts are listed within the Healthcare Menus Direct, LLC, recipe books and on the menu spreadsheet. (2) Ladles are sized according to their capacity.

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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 - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. (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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to prepare food by methods that conserve temperature when the puree corn salad was at 58 F (F, a degree of temperature), sweet potato fries and sweet tater tots were at 79 F at the beginning of trayline. This deficient practice placed 95 of 101 facility residents on regular (texture of food with no modifications and restrictions) and modified texture diet at risk of unplanned weight loss, a consequence of poor food intake, getting food from the kitchen. Based on observation, interview, and record review, the facility failed to prepare food by methods that conserve temperature when the puree corn salad was at 58 F (F, a degree of temperature), sweet potato fries and sweet tater tots were at 79 F at the beginning of trayline. This deficient practice placed 95 of 101 facility residents on regular (texture of food with no modifications and restrictions) and modified texture diet at risk of unplanned weight loss, a consequence of poor food intake, getting food from the kitchen. Findings: During a review of Resident 35's admission Record, the admission Record indicated the facility admitted Resident 35 on 10/11/2022 and was readmitted on [DATE] with diagnoses that included Parkinson's Disease (a progressive neurological disorders that affects movement, balance and coordination), muscle wasting and atrophy (a decrease in size and mass of muscle often resulting in weakness and reduced function) and essential hypertension (high blood pressure). During a review of Residents 35's Minimum Data Set (MDS- a resident assessment tool), dated 7/18/2025, the MDS indicated Resident 35 usually made self-understood and understand others. The MDS further indicated Resident 35 required supervision or touching assistance with eating while a resident of the facility and within the last seven days. During a review of Resident 35's diet order report dated 6/10/2025, the diet type report indicated Resident 35 was ordered fortified (addition of other food such as gravy, butter to food to increase calories and protein) large portion diet, mechanical soft (soft and chopped foods) texture, thin liquid consistency. During an interview on 8/11/2025 at 11:24 p.m. with Resident 35 inside the resident room, Resident 35 stated food was sometimes cold and unappetizing. During a review of the facility's daily spreadsheet (a list of food, amount of food that each diet would receive) titled Summer Menus, dated 8/11/2025, the spreadsheet indicated residents on regular (food with no restriction) texture diet would include sweet potato fries 1/2 cup (c, a household measurement) and dysphagia mechanical diet (diet consisting of food that are soft, chopped and moist) would include tator tots 1/2 c. During a review of the facility's daily spreadsheet titled Summer Menus, dated 8/11/2025, the spreadsheet indicated residents on puree (foods that are smooth and pudding-like consistency) and dysphagia mechanical would include puree corn slaw 1/3 c. During a concurrent observation and interview on 8/11/2025 at 11:54 a.m. of checking the food temperatures on the trayline (an area where foods were assembled from the steamtable to resident's plate) with [NAME] 1, observed [NAME] 1 tempted sweet potato fries at 79 F and sweet potato tator tots at 79 F using the facility thermometer. During an observation on 8/11/2025 at 11:58 a.m. of the trayline lunch service, observed the kitchen staff setting up milk, juice and coleslaw on the trays in the cart. During a concurrent observation and interview on 8/11/2025 at 12:28 p.m. of the test tray (a process of tasting, temping, and evaluating the quality of food) of a puree diet with the Dietary Supervisor (DS), observed the DS took the temperature of the puree corn salad using the facility thermometer. The DS stated the temperature of the puree corn salad was at 58 F. During an interview on 8/12/2025 at 12:39 p.m. with the DS, the DS stated the puree coleslaw salad was at 58 F and it was not okay because it was supposed to be at 41 F and below. The DS stated the temperature of the tator tots was at 150 F when it was cooked and 79 F in trayline. The DS stated she needed to call the menu company as the recipe indicated to cook the sweet potato fries and tator tots to 140 F and serve at 160-180 F. The DS stated the puree coleslaw salad, sweet potato fries were in the danger zone (41-135 F, a range of temperature where bacteria grow rapidly). The DS stated residents would refuse to eat food if it were not at an appetizing temperature and they could go hungry and lose weight as a potential outcome. During a review of the facility's P&P titled Food Preparation and Service dated 6/25/2025, the P&P indicated Food and Nutrition services employees prepare, distribute and serve food in a manner that complies with safe food and handling practices. (1) Danger zone means temperatures above 41 F to 135 F that allow the rapid growth of pathogenic microorganisms that can cause foodborne illness. Potentially Hazardous Foods (PHF) or Time and Temperature Control for Safety (TCS) Foods held in the danger zone for more than 4 hours (if being prepared from ingredients at ambient temperature) or 6 hours (if cooked and cooled) may cause a foodborne

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview, and record review, the facility failed to prepare foods in a form designed to meet individual needs when residents on puree diet/level four (4) received puree bread and puree beef were flat, and it did not hold its shape on the plate. This deficient practice had the potential to cause difficulty in eating, coughing, choking (to keep from breathing the normal way) and decrease of food intake resulting in weight loss for 18 of 101 residents on puree/level 4 diet. Findings:During a review of the facility's daily spreadsheet titled Summer Menus, dated 8/11/2025, the spreadsheet indicated residents on puree/level 4 diet would include the following foods on the tray: Puree roast beef moistened with broth 1/2 cup (c, a household measurement Puree roll 1/3 c Au jus 2 ounces (oz, a unit of measurement) Puree sweet potato fries 1/2 c. Puree corn coleslaw 1/3 c Cappuccino mousse 1/3 c Milk 4 ozDuring a concurrent observation and interview on 8/11/2025 at 12:32 p.m. of the puree/level 4 diet test tray (a process of tasting, temping, and evaluating the quality of food) with the Dietary Supervisor (DS), the DS stated they were following International Dysphagia Diet Standardization ([IDDSI], a global framework that standardized terminology and definitions for texture-modified foods and thickened liquids for individuals with difficulty swallowing) recipes and puree food should be pudding like consistency, blended, smooth, with no pieces of food. The DS stated puree food should not be runny and watery. The DS stated the texture of the puree food looks fine, but the puree bread and puree roast beef did not hold its shape on the plate and were flat. The DS stated the puree foods need to hold its shape on the plate because it could affect the presentation and it would not be appetizing to the residents. The DS stated residents on puree diet might have difficulty picking up the food using their silverware if the puree food was flat on the plate resulting to residents not eating and not getting the right amount of nutrients in their diets. The DS stated residents could potentially lose weight if they do not eat the puree food. During a review of the facility's Policies and Procedures (P&P) titled Facility Diet Manual, reviewed 5/28/2025, the document indicated, POLICY: Diet Manual is intended for use along with the menu system and its corresponding products. The purpose of this manual is to provide common language and a framework for communication among the facility's departments, healthcare providers, and residents (and their families) when communicating components of their nutritional care and management of within the facility. The manual includes descriptive overviews of each included diet, allowed foods and those to avoid, nutritional adequacy information, and a sample meal plan, with the goal that this will provide a realistic approach to the diets to make them adaptable to the individual needs of the residents. During a review of the facility's Diet Manual titled Regular Puree Diet, reviewed 5/28/2024, the diet manual indicated The pureed diet is a regular diet that has been designed for residents who have difficulty chewing and swallowing. The texture of the food should be smooth and moist consistency and able to hold its shape. Portions given will account for the addition of fluids and be specified on the spreadsheet. Detailed recipes and procedures for pureeing foods maybe found in binder #1, under the food and safety/miscellaneous section. Foods are prepared in a food processor and blender, with the exception of foods which are normally in a soft and smooth state such as pudding, ice cream, applesauce, mashed potatoes.During a review of the facility's recipe titled Recipe: Pureed (IDDSI LEVEL 4) Meats, undated, the recipe indicated, (5) The finished pureed items should be smooth and free of lumps, hold its shape, while not being too firm or sticky, and should not weep. The finished puree items must pass IDDSI level 4 testing requirements (i.e. the fork drip, fork pressure, and spoon tilt tests). During a review of facility's recipe titled Puree (IDDSI Level 4) Starch (Rice, Pasta, Polenta, Potatoes, etc.) undated, the recipe indicated, (5) The finished pureed items should be smooth and free of lumps, hold its shape, while not being too firm or sticky, and should not weep. The finished puree items must pass IDDSI level 4 testing requirements (i.e. the fork drip, fork pressure, and spoon tilt tests). During a review of the IDDSI guideline website titled IDDSI dated 7/2019, the IDSSI website indicated, Level 4 Pureed is usually eaten with spoon, falls off spoon in a single spoonful when tilted and continues to hold shape on the plate, no lumps, not sticky, and liquid must not separate from solid.

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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. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and food preparation practices in the kitchen when: 1. Kitchen equipment and kitchen areas were not free from dust, dirt, food debris.a. Reach in freezer bottom shelves had boxes particles dirt debris and the gasket was torn and had dirt buildup.b. The walk-in refrigerator floor had sticky food spills and had dirt.c. The walk-in freezer floor had ice and dirt debris.d. Ice machine vent had dust build up and its internal parts had white dirt debris coming out when wiped with a paper towel.2. Ten dented cans were stored with non-dented cans. 3. Kitchen utensils and equipment were not smooth and free from chips, cracks and scratches.a. Fifty cracked, and chipped trays were used for lunch service.b. [NAME] chopping board with scratches and black stains.4. Staff failed to perform handwashing and hand hygienea. [NAME] 1 did not perform handwashing after turning off the water faucet with her thumb and proceeded to work in the kitchen. b. Dietary Aide 1 (DA 1) touched her eyeglasses then proceeded to dish out food in trayline without washing her hands. 5. Staff failed to prevent cross-contamination (transfer of harmful bacteria from one place to another).a. [NAME] 1 got a spatula and wiped it on her apron then proceeded to use it in trayline without washing it. b. [NAME] 1 used the same perforated spoon (a large spoon with slots or holes for draining liquids) when serving diced carrots and broccoli.6. Dietary Aide 1 (DA 1) wore stacked of bracelets while preparing snacks and thickened water and Dietary Aide 2 (DA 2) wore silver bracelet while washing dishes. These failures had the potential to result in harmful bacterial growth and cross contamination that could lead to foodborne illness (a disease caused by consuming food or drinks that are contaminated by germs or chemicals) in 100 of 101 medically compromised residents who received food and ice from the kitchen. Findings: 1. a. During an observation on 8/11/2025 at 8:27 a.m. of the reach-in freezer, observed dirt debris at the bottom shelves, the gasket was torn and had dirt build up. During a concurrent observation and interview on 8/11/2025 at 8:55 a.m. with the Dietary Supervisor (DS), the DS stated there were dirt debris from the boxes on the bottom shelves of the reach in freezer and gasket was torn too. The DS stated they cleaned the freezer every Friday during delivery, and it is important to clean the freezer and refrigerator because there was food inside. The DS stated if the freezer was not clean, it could contaminate the food and would cause residents to get sick of stomach problems, salmonella and food borne illnesses. The DS stated the gasket should be fixed to maintain the freezer temperature to prevent food borne illnesses. b. During an observation on 8/11/2025 at 8:32 a.m. of the walk-in refrigerator, observed dirt debris on the floor. During an interview on 8/11/2025 at 9:01 a.m. with the DS, the DS stated she checked the walk-in refrigerator floor was sticky and there was dirt on the floor. The DS stated staff was off last weekend and staff did not clean the floor. The DS stated the potential outcome for not cleaning the floor would be cross-contamination to food. c. During an observation on 8/11/2025 at 8:43 a.m. of the walk-in freezer, observed dirt and ice particles on the floor. During an interview on 8/11/2025 at 9:05 a.m. with the DS, the DS stated she checked the walk-in freezer and there were little chips and ice debris needing cleaning to prevent cross-contamination. d. During an observation on 8/11/2025 at 11:48 a.m. of the ice machine, observed the vent had dust particles. During a concurrent observation and interview on 8/11/2025 at 1:23 p.m. of an ice machine, observed an off-white dirt particle coming out from the internal parts of the ice machine when wiped with a paper towel. The DS stated the off-white particles were hard water residues and the filter had dust buildup. The DS stated maintenance staff cleaned the ice machine on 7/8/2025 but once a month cleaning would not be sufficient. The DS stated a possible cross contamination of dirt to ice would be the potential outcome of not cleaning the ice machine. During a review of the facility's policy and procedure (P&P) titled Refrigerator and Freezer dated 6/25/2025, the P&P indicated Maintaining a clean refrigerator and freezer can improve the safety and quality of your foods. For the best cleaning results, always refer to your owner's manual. (1) Refrigerator and freezer should be on a weekly cleaning schedule. (2) Wipe up spills immediately (5) Wipe down gaskets with soapy water. How to keep your refrigerator and freezer working efficiently: (2) Periodically check door gasket and replace, if damaged. During a review of the facility's P&P titled Sanitation dated 6/25/2025, the P&P indicated (14) Ice which is used in connection with food or drink shall be from a sanitary source and shall be handled and dispensed in a sanitary manner. During a review of the facility's P&P titled Ice Machine Cleaning Procedures dated 6/25/2025, the P&P indicated Policy: The ice machine needs to be cleaned and sanitized monthly. The internal components cleaned monthly per manufacturer's recommendations, and the date recorded when cleaned. (3) Clean inside of the ice machine with a sanitizing agent per the manufacturer's instructions

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to dispose garbage and refuse properly when one (1) of three (3) dumpsters (a movable waste container designed to be brought and taken away by a special collection vehicle, or to a bin that a specially designed garbage truck lifts) were not covered while not actively being used and there were trashes, empty cups, paper towel and salsa spills on the floor. This failure had potential to attract birds, flies, insects, pests and possibly spread infection to 100 of 101 facility residents.Findings: During a concurrent observation and interview on 8/12/2025 at 10:10 a.m. of the dumpster with the Dietary Supervisor (DS), observed one dumpster was overfilled with trash, not completely covered, and there were salsa drippings and plastic cans, paper towel on the dumpster floor. The DS stated the trash bin should always be kept close to prevent flies, insects and rodents going close to the facility and so that trash would not be spilling from the dumpster floor. The DS stated there were salsa spills, paper towels and empty plastic cups on the floor. The DS stated insects, rodents and flies could get in the facility and to the residents' food transmitting dirt they carry. The DS stated insects could transmit disease to the resident as a potential outcome. During an interview on 8/12/2025 at 2:49 p.m. with the Director of Nursing (DON), the DON stated the dumpster cover was not closed and there was trash on the floor around the dumpster surroundings. The DON stated the dumpster cover was supposed to be kept close, and the surroundings must be cleaned to avoid flies, rodents' homeless people and other residents could go in the trash and spread infection to residents for potential outcome. During a review of the facility's policies and procedures (P&P) titled Food-Related Garbage and Rubbish Disposal dated 6/25/2025, the P&P indicated Food-related garbage and rubbish shall be disposed of in accordance with current state laws regulating such matters. Outside dumpsters provided by garbage pickup services will be kept closed and free of surrounding litter. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 5-501.116 Cleaning Receptacles. Proper storage and disposal of garbage and refused are necessary to minimize the development of odors, prevent such waste from becoming an attractant and harborage of breeding place for insects and rodents, and prevent the soiling of food preparation and food service areas. Improperly handled garbage creates nuisance conditions, makes housekeeping difficult, and may be possible source of contamination of food, equipment, and utensils. Outside receptacles must be constructed with tight-fitting lids or covers to prevent the scattering of the garbage or refuse by birds, the breeding of flies, or the entry of rodents. Proper equipment and supplies must be made available to accomplish thorough and proper cleaning of garbage storage areas and receptacles so that unsanitary conditions can be eliminated.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain timely and accurate resident medical records in accordance with accepted professional standards by failing to: 1. Complete timely documentation of a resident's urinary catheter care (flexible tube passed into the bladder to drain urine) for one of two sampled residents (Resident 15) reviewed under the urinary catheter care area.2. Document the application of a resident's splint for one of three sampled residents (Resident 55) reviewed under the care area of position/mobility, when Resident 55's left resting hand splint (brace secured with straps that extends from the fingers to the forearm to properly position the fingers and wrist and prevent contractures) and left elbow extension splint (brace designed to help maintain or improve the range of motion at the elbow joint, specifically focusing on the ability to straighten or extend the arm) application were not documented in the Restorative Nursing Aide ([RNA nursing aide program that helps residents to maintain their function and joint mobility) Documentation Survey Report (record of nursing assistant tasks). These failures had the potential to portray an inaccurate reflection of the delivery of care for Resident 15 and resulted in inaccurate medical records consistent with Resident 55's physician's orders and plan of care.Findings: a. During a review of Resident 15’s admission Record, the admission Record indicated the facility originally admitted Resident 15 on 2/8/2025 and re-admitted the Resident 15 on 7/12/2025, with diagnoses including hypertension (high blood pressure), hyperlipidemia (high concentration of fats in the blood), depression and neuromuscular dysfunction of the bladder. During a review of Resident 15’s History and Physical (H&P), dated 7/14/2025, the H&P indicated Resident 15 had the capacity to understand and make decisions. During a concurrent interview and record review on 8/12/2025 at 2:57 p.m. of Resident 15’s Physician Orders with Licensed Vocational Nurse (LVN) 1, LVN 1 stated that Resident 15 is her assigned resident for the 7:00 a.m. to 3:00 p.m. shift. LVN 1 stated Resident 15 has an active order for urinary catheter care every shift. LVN 1 stated that urinary catheter care was provided for Resident 15 in the morning around 9:00 a.m. by LVN 1. During a concurrent interview and record review on 8/12/2025 at 2:57 p.m. of Resident 15’s Electric Treatment Administration Record (ETAR), LVN stated that the ETAR did not indicate that urinary catheter care was provided around 9:00 a.m. for Resident 15. LVN 1 stated she provided urinary catheter care at approximately 9:00 a.m. but forgot to document it. LVN 1 stated this inaccuracy in charting could lead for the oncoming shift to believe urinary catheter care was not provided. LVN 1 stated, “If it’s not charted, it wasn’t done.” LVN 1 stated that it is important to document care as soon as it is provided to ensure accurate records. LVN 1 stated that failure to document urinary catheter care could reflect that the physician’s order was not followed. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review of the urinary catheter care administration history on 8/14/2025 at 1:55 p.m. with the Director of Nursing (DON), the DON stated that the administration history indicated urinary catheter care for Resident 15 was documented on 8/12/2025 at 3:31 p.m., and not at “around 9:00 a.m.” as reported by LVN 1. The DON stated this was an inaccuracy in documentation and resident care. The DON stated that inaccurate documentation could potentially result in care not being provided as ordered by the physician. The DON further stated that urinary catheter care should be documented immediately after completion to ensure accurate records of care. During a review of the facility’s policy and procedure (P&P) titled “Charting and Documentation, ” dated 7/2025, the P&P indicated, “2. The following information is to be documented in the resident medical record: c. Treatments or services performed. 3. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. 7. Documentation of procedures and treatments will include care-specific details, including a. the date and time the procedure /treatment was provided.” b. During a review Resident 55’s admission Record, the admission Record indicated the facility admitted Resident 55 on 10/23/2021 with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) following cerebral infarction (brain damage due to a loss of oxygen to the area) affecting the left non-dominant side, dysphagia (difficulty swallowing), muscle weakness, left upper arm contracture (a stiffening/shortening at any joint that reduces the joint’s range of motion) of the muscle, and dementia (progressive state of decline in mental abilities). During a review of Resident 55’s physician’s orders, dated 5/17/2024, the physician’s order indicated Restorative Nursing Aide ([RNA] nursing aide program that helps residents to maintain their function and joint mobility) to apply a left resting hand splint and left elbow extension splint, seven times per day for two to three hours (2-3 hours) as tolerated. During a review of Resident 55’s physician’s orders, dated 6/7/2024, the physician’s orders indicated RNA for passive range of motion ([PROM] movement of a joint through the range of motion with no effort from person) on the left arm, seven days per week as tolerated. During a review of Resident 55’s Occupational Therapy ([OT] profession aimed to increase or maintain a person's capability of participating in everyday life activities [occupations]) Evaluation and Plan of Treatment, dated 5/28/2025, the OT Evaluation indicated Resident 55’s range of motion ([ROM] full movement potential of a joint) in the right arm was within functional limits ([WFL] sufficient joint movement without significant limitation). The OT Evaluation indicated Resident 55 had ROM limitations on the left shoulder, elbow, wrist, and finger joints. During a review of Resident 55’s care plan titled, “Restorative Nursing – Range of Motion,” initiated 6/4/2025, the care plan interventions included RNA for PROM on both arms and application of the left-hand splint for 2-4 hours per day and left elbow extension splint for 2-4 hours per day, seven days per week as tolerated. During a review of Resident 55’s OT Discharge summary, dated [DATE], the OT Discharge Summary recommendation indicated RNA to provide PROM on Resident 55’s left arm, seven days per week as tolerated, and application of the left resting hand splint and left elbow extension splint, 2-3 hours per day, seven days per week. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 55’s Minimum Data Set ([MDS] a federally mandated resident assessment tool), dated 7/30/2025, the MDS indicated Resident 55 had clear speech, had difficulty communicating some words or finishing thoughts, usually understood verbal content, and had severely impaired cognition (ability to think, understand, learn, and remember). The MDS indicated Resident 55 required setup or clean-up assistance (helper sets up or cleans up while resident completes the activity, helper assists only prior to or following the activity) for eating, supervision or touching assistance (helper provides verbal cues and/or touching and/or steadying assistance as resident completes the activity) for upper body dressing, partial/moderate assistance (helper does less than half the effort) for rolling and sit-to-stand transfers, and substantial/maximal assistance (helper does more than half the effort) for lower body dressing and chair/bed-to-chair transfers. During a review of Resident 55’s RNA Documentation Survey Report (record of nursing assistant tasks) for 8/2025, the Documentation Survey Report for 8/12/2025 indicated RNA 1 applied splints to both arms. During an observation on 8/13/2025 at 2:37 p.m. with Restorative Nursing Assistant 1 (RNA 1) in the resident’s room, Resident 55’s RNA session was observed. Resident 55 was alert and sitting up in a wheelchair. Resident 55’s left shoulder joint was rotated toward the resident’s body, the left elbow was bent, the left wrist was bent downward, and the left-hand fingers were in a loosely closed fist. RNA 1 performed ROM exercises to Resident 55’s left shoulder, elbow, wrist, and hand. RNA 1 then applied the resting hand splint and the elbow extension splint to Resident 55’s left arm. During an interview on 8/13/2025 at 3:04 p.m. with RNA 1, RNA 1 stated Resident 55 received PROM on the left arm and application of the left hand and elbow splints. During a review of Resident 55’s RNA Documentation Survey Report for 8/2025, the Documentation Survey Report for 8/13/2025 indicated RNA 1 applied splints to both arms. During a concurrent interview and record review on 8/14/2025 at 1:18 p.m. with the Assistant Director of Nursing (ADON), Resident 55’s RNA Documentation Survey Report for 8/2025 was reviewed. The ADON stated Resident 55 did not have splints for both arms. The ADON stated Resident 55’s RNA Documentation Survey Report was inaccurately documented for 8/12/2025 and 8/13/2025. During an interview on 8/14/2025 at 1:59 p.m. with the ADON, the ADON stated the purpose of the medical record (in general) was to document the services provided to the residents. The ADON stated the medical record should be accurate to reflect the resident’s care. During a review of the facility’s policy and procedure (P&P) titled, “Charting and Documentation,” revised 7/2025, the P&P indicated documentation in the medical record will be objective, complete, and accurate.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to: 1. Ensure a resident's nasal cannula (device used to deliver supplemental oxygen placed directly on a resident's nostrils) oxygen tubing was dated for one of one sampled resident (Resident 125) reviewed under the respiratory care area. This deficient practice had the potential to result in contamination of the resident's care equipment and risk of transmission of bacteria that can lead to infection. 2. Ensure a resident's urinary catheter (a flexible tube inserted into the bladder to drain urine) system was labeled for one of two sampled residents (Resident 15) reviewed under the catheter care area. This deficient practice placed Resident 15 at risk for infections and prolonged use of an old urinary catheter. 3. Ensure a staff member donned (put on) an isolation gown (type of personal protective equipment [PPE- specialized clothing or equipment worn by an employee for protection against infectious materials] used in healthcare settings to protect healthcare personnel from the spread of infection or illness, particularly from contact with blood and body fluids) prior to providing urinary catheter care to a resident on enhanced barrier precautions (EBP -a set of infection control practices that use PPE to reduce exposure to reduce the spread of multidrug-resistant organisms [MDROs -microorganisms that are resistant to multiple classes of antibiotics and antifungals] in nursing homes) for one of two sampled residents (Resident 15) reviewed under the catheter care area. This deficient practice had the potential to increase the risk of spreading infection to other residents and staff. 2. During a review of Resident 15’s admission Record, the admission Record indicated the facility originally admitted Resident 15 on 2/8/2025 and re-admitted Resident 15 on 7/12/2025, with diagnoses including hypertension (high blood pressure [the force of the blood pushing on the blood vessel walls is too high]), urinary tract infection (UTI- an infection in any part of the urinary system), and neuromuscular dysfunction of the bladder (urinary conditions in people who lack bladder control due to a brain, spinal cord, or nerve problem). During a review of Resident 15’s History and Physical (H&P), dated 7/14/2025, the H&P indicated Resident 15 had the capacity to understand and make decisions. During a concurrent observation and interview on 8/12/2025 at 2:40 p.m., in Resident 15’s room with Licensed Vocational Nurse 1 (LVN 1), observed Resident 15’s indwelling urinary catheter system. LVN 1 stated Resident 15’s urinary catheter system did not have a written date and time and initials on it. LVN 1 stated the date and time on the urinary catheter would indicate the last time the urinary catheter tube and/or urine collection bag were changed. LVN 1 stated that it is important to have the urinary catheter system dated and signed correctly to know when the next time the urinary catheter should be changed based on doctors’ orders. LVN 1 stated that not having the proper date and time on the urinary catheter can prolong the use of an old urinary catheter and increase Resident 15’s risk for prolong urinary tract infection. During a concurrent observation and interview on 8/12/2025 at 2:57 p.m. in Resident 15’s room with Certified Nurse Assistant 1 (CNA 1), observed CNA 1 emptying out the urine from Resident 15’s urinary catheter bag without using proper PPE. CNA 1 was observed using only gloves and did not have a gown on per EBP for Resident 15. CNA 1 stated that he (CNA 1) forgot to put on a gown prior to providing urinary catheter care for Resident 15. CNA 1 stated that it is important for EBP precautions to be followed correctly and at all times to reduce the risk of spreading potential infections to the residents. CNA 1 stated that not wearing the correct PPE placed Resident 15 at risk for an increase in infections. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/14/2025 at 1:55 p.m., with the Director of Nursing (DON), the DON stated it is important that urinary catheter tubing and urine collection bags are properly dated and initialed at the time of placement. The DON stated that failure to date this equipment could contribute to the development of UTIs or prolong existing UTIs, as an undated urinary catheter may remain in place for an extended period without being identified for timely change. The DON stated that Resident 15’s urinary catheter and urine collection bag should have been dated when placed. The DON stated that Resident 15’s EBP must always be followed by the staff responsible for providing care. The DON stated that EBP precaution signage is posted outside resident rooms to serve as a reminder to staff regarding the type of PPE that must be worn prior to providing resident care. During a review of the facility’s policy and procedure (P&P) titled, “Enhanced Barrier Precautions,” dated 6/2025, the P&P indicated, “Enhanced barrier precautions are utilized to prevent the spread of infections and control interventions designed to reduce the transmission of multi-drug-resistant organisms during high contact resident care. Enhanced barrier precautions apply when: Indwelling medical devices include urinary catheters….EBPs employ targeted gown and glove use in addition to standard precautions during high contact resident care activities when contact precautions do not otherwise apply…Gloves and gown are applied prior to performing the high contact resident care activity (as opposed…Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: device care or use (urinary catheter…)… Enhanced barrier precautions are in place for the duration of the resident's stay or until resolution of the wound or discontinuation of the indwelling medical device that place that at higher risk.” During a review of the facility’s policy and procedure (P&P) titled, “Indwelling (Foley) Catheter Insertion, Female Resident,” dated 7/2025, the P&P indicated, “The purpose of this procedure is to provide guidelines for the aseptic insertion of an indwelling foley urinary catheter in a female resident. – Documentation: 1. The date and time the procedure was performed. 3. The name and title of the individual(s) who performed the procedure.” Findings: 1. During a review of Resident 125's admission Record, the admission Record indicated the facility originally admitted the resident on 7/5/2024 and readmitted the resident on 8/10/2025 with diagnoses including facial weakness, pneumonia (infection that affects one or both lungs), and muscle weakness. During a review of Resident 125's Minimum Data Set (MDS- a resident assessment tool) dated 7/30/2025, the MDS indicated the resident had the ability to usually make self-understood and had the ability to usually understand others. The MDS further indicated that Resident 124 was totally dependent on staff with activities of daily living (ADL- activities related to personal care). During a review of Resident 125`s physician orders dated 8/10/2025, the physician orders indicated an order to administer oxygen at two (2) liters per minute (LPM- unit of measurement) via nasal cannula every shift. (continued on next page)

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	08/14/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 8/11/2025 at 10:18 a.m., with the Infection Preventionist Nurse (IPN) in Resident 125’s room, observed Resident 125 wearing a nasal cannula. Observed Resident 125’s nasal cannula oxygen tubing and the IPN stated that Resident 125’s oxygen tubing was not labeled with a date. The IPN stated that oxygen tubing is replaced every Wednesday and as needed and the oxygen tubing is dated so the nurses know when to replace the tubing. The IPN stated that replacing tubing regularly is for infection prevention protocol since tubing can get contaminated and can potentially cause respiratory illness. During a review of the facility`s policy and procedure titled, &ldquo;Oxygen Administration,&rdquo; last reviewed on 6/25/2025, the policy indicated, &ldquo;The purpose of this procedure is to provide guidelines for safe oxygen administration&hellip;review the physician`s orders or facility protocol for oxygen administration.”

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	08/14/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. Based on observation, interview and record review, the facility failed to provide at least 80 square feet (sq. ft. - unit of measurement) per resident in multiple resident bedrooms for the four out of 38 resident rooms (Rooms 1, 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). This deficient practice had the potential to result in inadequate useable living space for all the residents and inadequate working space for the health caregivers. Findings: During a review of the Request for Room Size Waiver letter dated 3/26/2025, submitted by the Administrator, the letter indicated the rooms did not meet the 80 square feet requirement per federal regulation. The letter indicated the residents' beds were in accordance with the special needs of the residents and will not adversely affect the residents' health and safety and do not impede the ability of the residents in that room to obtain their highest practicable well-being. The following rooms provided less than 80 square feet per resident:Rooms # Beds Floor Area Sq. Ft. Sq. Ft/Resident1 3 235.7 78.52 3 235.7 78.53 3 235.7 78.55 3 235.7 78.57 3 235.7 78.59 3 235.7 78.5 15 3 235.7 78.5 17 3 235.7 78.519 3 235.7 78.521 3 235.7 78.523 3 235.7 78.525 3 235.7 78.526 3 235.7 78.528 3 235.7 78.530 3 235.7 78.531 3 235.7 78.536 3 235.7 78.537 3 235.7 78.539 3 235.7 78.541 3 235.7 78.542 3 235.7 78.543 3 235.7 78.544 3 235.7 78.545 3 235.7 78.546 3 235.7 78.547 3 235.7 78.548 3 235.7 78.5 The minimum square footage for a 3-bed room should be 240 sq. ft. During the Resident Council meeting on 8/12/2025 at 10:30 a.m., no concerns were brought up by the residents regarding the size of the rooms. During the general observation of the residents' rooms on 8/12/2025 and 8/13/2025, the residents had ample space to move freely inside the rooms. There was sufficient space to provide freedom of movement for the residents and for nursing staff to provide care for the residents. There was also sufficient space for beds, side tables, and resident care equipment. During interviews with staff on 8/14/2025 at 10:39 a.m., there were no concerns regarding the size of rooms 1, 2, 3, 5, 7, 9, 15, 17, 19, 21, 23, 26, 28, 30, 31, 36, 37, 39, 41, 42, 43, 44, 45, 46, 47 and 48. The facility submitted a written request for continued waiver.