STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055856	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
High Valley Lodge	7912 Topley Lane Sunland, CA 91040

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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 - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide feeding assistance at eye-level to one of nine residents (Resident 2) on 8/5/2025 during lunch.This deficient practice had the potential to negatively impact Resident 2's self-esteem and self-worth and increased the risk of aspiration (inhaling or drawing something into the lungs or airways that was not air), which could lead to serious complications (a medical problem that occurred during a disease) such as pneumonia (an infection/inflammation in the lungs). Findings:During a review of Resident 2's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 2 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including hemiplegia (total paralysis [the loss or impairment of voluntary movement] of the arm, leg, and trunk on the same side of the body), epilepsy (a brain disorder characterized by recurrent, unprovoked seizures [a sudden, uncontrolled electrical disturbance in the brain which could cause uncontrolled jerking, blank stares, and loss of consciousness]), diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), and dysphagia (difficulty swallowing). During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool), dated 6/2/2025, the MDS indicated Resident 2's cognitive (the ability to think and process information) skill for daily living was severely impaired. The MDS indicated Resident 2 was dependent (helper did all the effort) on staff with eating, oral hygiene, toileting hygiene, showering/ bathing self, personal hygiene, and bed-to-chair transferring. During a review of Resident 2's Physician Order Report for 7/2025, the Physician Order Report indicated to give Resident 2 Pureed (food consistency that did not require chewing, often for individuals with swallowing difficulties), Consistent Carbohydrate (CCHO, diet used for individuals with diabetes to manage blood sugar levels), NAS (No Added Salt) diet. During a concurrent observation and interview on 8/5/2025 at 12:38 p.m. with Certified Nursing Assistant (CNA) 4, in Resident 2's room, CNA 4 was sitting in front of Resident 2's Geri chair (specialized chair designed for individuals with limited mobility) while providing feeding assistance to Resident 2. Resident 2's Geri chair was not in an upright position and CNA 4 and Resident 2 were not at eye-level. CNA 4 stated she reclined the Geri chair to prevent Resident 2 from falling forward. During a concurrent observation and interview on 8/5/2025 at 12:45 p.m. with Licensed Vocational Nurse (LVN) 1, in Resident 2's room, CNA 4 was not feeding Resident 2 at eye-level. LVN 1 stated Resident 2 was lying on the Geri chair while eating and needed to be positioned more upright to prevent aspiration. LVN 1 stated the food could enter Resident 2's lungs and cause pneumonia. During an interview on 8/7/2025 at 1:02 p.m. with the Director of Nursing (DON), the DON stated residents needed to be positioned upright as much as they could tolerate to prevent aspiration and choking. The DON stated CNAs needed to be at eye-level with residents when providing feeding assistance to maintain residents' dignity. The DON stated that all staff in the facility were responsible for protecting residents' dignity. During a review of the facility's Job Description for CNAs, undated, the Job Description indicated, the CNAs' responsibilities included Provide care in a manner which protects the dignity, respect and self-esteem of the resident. During a review of the facility's Policy and Procedure (P&P) titled Assistance with meals, revised on 10/2009, the P&P indicated, Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity, for example: (1) Not standing over residents while assisting them with meals. During a review of the facility's P&P titled Quality of life-dignity, revised on 10/2009, the P&P indicated, Residents shall be treated with dignity and respect at all times. ‘Treated with dignity' means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth.em and self-worth.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the Minimum Data Set ([MDS] - a resident assessment tool), accurately reflected the oral/dental status for one of six sampled residents (Resident 35). This deficient practice resulted in incorrect data being transmitted to the Center for Medicare and Medicaid Services (CMS) regarding Resident 35's oral/dental status and had the potential to negatively affect the resident care plan and delivery of necessary care and services.Findings:During a review of Resident 35's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 35 was originally admitted to the facility on [DATE] and re admitted on [DATE] with diagnoses including schizophrenia (a mental illness that is characterized by disturbances in thought), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), dementia (a progressive state of decline in mental abilities), and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 35's MDS, dated [DATE], the MDS indicated Resident 35's cognition (the ability to think and process information) was impaired. The MDS indicated Resident 35 was dependent (helper does all the effort) on staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS indicated Resident 35 was assessed as not having any oral and/or dental issues. During a concurrent observation and interview on 8/5/2025 at 8:35 a.m. with Resident 35 in Resident 35's room, Resident 35 was observed sitting on the bed, eating her breakfast. Resident 35 stated it was hard to chew the food because she did not have her natural teeth. During a concurrent interview and record review on 8/6/2025 at 8:10 a.m., with the Minimum Data Set Nurse (MDSN), Resident 35's MDS, dated [DATE], section oral/dental status was reviewed. The MDSN stated the MDS indicated Resident 35 was assessed as not having any oral and/or dental issues. The MDSN stated the coding was inaccurate as it did not reflect the resident's actual oral and/or dental status. The MDSN stated Resident 35 did not have her natural teeth therefore the MDS should have been coded to accurately reflect the resident's oral/dental status. The MDSN stated accurate MDS coding was important for quality measures, which affect quality of care monitoring, outcome measurement, resident perception, and care planning. The MDSN stated inaccuracy of the MDS had the potential to result in the resident's care needs and services not being met. During a review of the facility's policy and procedure (P&P) titled Resident Assessment Instrument (RAI), dated 4/30/2025, the P&P indicated the facility would ensure an accurate assessment of residents that would accurately reflect the resident's status. The P&P indicated a registered nurse would sign and certify the accuracy of the assessment.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a comprehensive, person-centered care plan was developed and implemented to address depression (a mental health disorder) diagnosis for one of six sampled residents (Resident 8). This deficient practice placed Resident 8 at risk of not receiving appropriate care and resident-centered interventions to meet the resident's needs and services related to depression. Findings:During a review of Resident 8's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 8 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses included depression, dementia (a progressive state of decline in mental abilities), and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 8's Minimum Data Set ([MDS] - a resident assessment tool), dated 5/19/2025, the MDS indicated Resident 8's cognition (the ability to think and process information) was impaired. The MDS indicated Resident 8 was dependent (helper does all the effort) on staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a concurrent interview and record review on 8/6/2025 at 8:50 a.m., with the Minimum Data Set Nurse (MDSN), Resident 8's MDS, dated [DATE], and care plans, dated 3/2025 through 8/2025, were reviewed. The MDS indicated Resident 8's depression was an active diagnosis. The care plans did not address Resident 8's depression diagnosis. The MDSN stated Resident 8's depression should have been addressed in the care plan with individualized, person-centered interventions to support the resident's emotional and mental health needs. The MDSN stated there were no care plan goals or interventions specific to depression. The MDSN stated the failure to address an identified active diagnosis in the resident's care plan placed Resident 8 at risk for not receiving the necessary care and services related to depression, which could potentially impact the resident's emotional well-being and quality of life. During an interview on 8/7/2025 at 8:58 a.m., with the Director of Nursing (DON), the DON stated care plans were developed to guide the care for each resident. The DON stated all active diagnoses, including depression, must be addressed in the resident's care plan with individualized goals and interventions. The DON stated Resident 8 should have had a care plan developed to address depression to ensure the resident was properly monitored for depression behaviors. The DON stated without a care plan, Resident 8 was at risk for undetected and/or worsening depression behaviors. During a review of the facility's policy and procedure (P&P) titled Care Plans-Comprehensive, revised 12/2010, the P&P indicated the facility would develop and implement an individualized comprehensive care plan that includes measurable objectives to meet each resident's medical, nursing, mental and psychological needs.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. (continued on next page)

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F 0657 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 revise the comprehensive care plan (a detailed, resident-centered document outlining all aspects of a person's healthcare needs, including medical, social, and emotional support, and was designed to promote overall well-being) for three out of three sampled residents (Residents 2, 3, and 7) when:1. Resident 2's diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) care plan did not reflect the active insulin (a hormone that removed excess sugar from the blood, could be produced by the body or given artificially via medication) orders. 2. Resident 3's dementia (a progressive state of decline in mental abilities) care plan did not reflect the active namenda (a medication used to treat dementia) order. Resident 3's antidepressant (medications used to treat depression [a common mental health condition characterized by persistent feelings of sadness, hopelessness, and loss of interest in activities that were once pleasurable]) care plan did not reflect the active lexapro (a medication used to treat depression) order.3. The facility did not revise Resident 7's care plan for risk for spontaneous fracture ([pathological fracture]a bone fracture that occurs with minimal or no trauma, often due to underlying bone weakness). These deficient practices increased the potential for staff to be unaware of the interventions required for Residents 2,3, and 7 to maintain their highest practicable physical, mental, and psychosocial well-beings. Findings: a. During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 2's diagnoses included DM and long-term use of insulin. During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool), dated 6/2/2025, the MDS indicated Resident 2's cognitive (the ability to think and process information) skill for daily living was severely impaired. The MDS indicated Resident 2 was dependent (helper did all the effort) on staff with eating, oral hygiene, toileting hygiene, showering/ bathing self, personal hygiene, and bed-to-chair transferring. The MDS indicated Resident 2 received insulin daily. During a review of Resident 2's Physician Order Report for 7/2025, the Physician Order Report indicated to start insulin aspart (a fast-acting insulin used to control blood sugar levels for diabetic residents) per sliding scale (a method of administering insulin based on a resident's current blood sugar level) subcutaneously (beneath the skin) before meals on 4/21/2025. The Physician Order Report further indicated to start insulin glargine (a long-acting insulin used to control blood sugar levels for diabetic residents) 30 units subcutaneously daily on 6/25/2025. During a concurrent interview and record review on 8/6/2025 at 12:51 p.m. with the MDS Nurse (MDSN), Resident 2's care plan for diabetes, revised on 6/2025, was reviewed. The MDSN stated the care plan interventions did not reflect the current insulin orders and should reflect. The MDSN stated it would potentially delay the necessary care. The MDSN stated the care plan was a guideline for staff to safely provide resident care. The MDSN stated the care plan should be specific and resident-centered, so the staff would know how to care for the residents. The MDSN stated all licensed nurses could update and revise the care plans when they received the new medication orders and as needed. During a concurrent interview and record review on 8/7/2025 at 9:46 a.m. with the Director of Nursing (DON), Resident 2's care plan for diabetes, revised on 6/2025, was reviewed. The DON stated the care plan intervention, Administer medications as ordered, was too generic. The DON stated the care plan interventions should be resident-centered and individualized because diabetic residents did not get the same medications. The DON stated the MDSN updated the residents' care plans quarterly and as needed. The DON stated the MDSN should have caught it during the care plan reviewed on 6/2025. The DON stated the purpose of the care plan was to show a complete picture of a resident, to address the potential and/or actual problems, to prevent any declines, and to maintain residents' highest practicable well-being. The DON stated residents' medications should be reflected in the care plans to show the staff the plan of care. The DON stated it was better practice for the licensed nurses to update the care plan once they received the order, so the care plan could be more up to date. b. During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was admitted to the facility on [DATE] with diagnoses of dementia and depression. During a review of Resident 3's MDS, dated [DATE], the MDS indicated Resident 3's cognitive skill for daily living was severely impaired. The MDS indicated Resident 3 was independent (resident completed the activity by herself with no assistance from a helper) with toileting hygiene and bed-to-chair transferring. The MDS indicated Resident 3 required setup assistance from staff with eating. The MDS indicated Resident 3 required supervision from staff with oral and personal hygiene. The MDS indicated

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (continued on next page)

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F 0658 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 meet professional standards of care for two of two sampled residents (Resident 38 and Resident 40), when Licensed Vocational Nurse (LVN) 2 administered antihypertensive medications (used to treat high blood pressure using blood pressure readings obtained two hours prior to administration. This deficient practice increased the risk for hypotension (low blood pressure), dizziness, and falls for Residents 38 and 40. Findings: 1. During a review of Resident 38's admission Record, the admission Record indicated Resident 38 was admitted to the facility on [DATE]. Resident 38's diagnoses included hypertension (HTN, high blood pressure), osteoporosis (weak and brittle bones due to lack of calcium and Vitamin D), and dementia (a progressive state of decline in mental abilities). During a review of Resident 38's Minimum Data Set (MDS- a resident assessment tool), dated 7/2/2025, the MDS indicated Resident 38's cognitive skills (ability to think, remember and reason) for daily decision making was moderately impaired. The MDS indicated Resident 38 was independent with walking and transferring from bed to chair. The MDS indicated Resident 38 required setup assistance from staff with eating, oral hygiene, toileting hygiene, and personal hygiene. The MDS indicated Resident 38 required partial assistance (helper did less than half the effort) with showering/ bathing. During a review of Resident 38's Physician Order Report for 7/2025, the Physician Order Report indicated to start lisinopril (medication used to treat HTN) 40 milligrams (mg- metric unit of measurement) daily on 6/20/2025. The Physician Order Report indicated to hold lisinopril if Resident 38's systolic blood pressure (SBP- the pressure of blood against artery walls when the heart contracted and pumped blood out) was less than 110 millimeters of mercury (mmHg- the unit used to measure blood pressure) or if the resident's heart rate was less than 60 beats per minute (BPM). During a medication pass observation on 8/5/2025 at 9:28 a.m. with Licensed Vocational Nurse (LVN) 2, observed LVN 2 administer lisinopril 40 mg without checking Resident 38's blood pressure. LVN 2 stated Resident 38's SBP was 150 mmHg at 7:36 am. 2. During a review of Resident 40's admission Record, the admission Record indicated Resident 40 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 40's diagnoses included HTN, dizziness and giddiness, and epilepsy (a brain disorder characterized by recurrent, unprovoked seizures [a sudden, uncontrolled electrical disturbance in the brain which could cause uncontrolled jerking, blank stares, and loss of consciousness]). During a review of Resident 40's MDS, dated [DATE], the MDS indicated Resident 40's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 40 was independent with walking and transferring from bed to chair. The MDS indicated Resident 40 required setup assistance from staff with eating, oral hygiene, toileting hygiene. The MDS indicated Resident 40 required supervision from staff with personal hygiene. The MDS indicated Resident 40 required partial assistance (helper did less than half the effort) with showering/ bathing. During a review of Resident 40's History and Physical (H&P), dated 7/18/2024, the H&P indicated Resident 40 had the capacity to understand and make decisions. During a review of Resident 40's Physician Order Report for 7/2025, the Physician Order Report indicated to start amlodipine (medication used to treat HTN) 10 mg daily on 5/29/2025. The Physician Order Report indicated to hold amlodipine if Resident 40's SBP was less than 110 mmHg. The Physician Order Report indicated to start metoprolol (medication used to treat HTN) 50 mg twice a day on 2/16/2024. The Physician Order Report indicated to hold metoprolol if Resident 40's SBP was less than 110 mmHg and/or heart rate was less than 60 beats per minute (BPM). During a medication pass observation on 8/5/2025 at 9:37 a.m. with LVN 2, observed LVN 2 administered amlodipine 10 mg and metoprolol 50 mg to Resident 40 without checking Resident 40's blood pressure. LVN 2 stated Resident 40's SBP was 150 mmHg with heart rate of 77 BPM at 7:36 am. During an interview on 8/5/2025 at 2:01 p.m. with LVN 2, LVN 2 stated she should have taken Resident 38 and 40's blood pressure within an hour of the medication administration time because the blood pressure could fluctuate. LVN 2 stated the risk of administered antihypertensive medications using blood pressure readings obtained two hours prior to administration was hypotension (low blood pressure). LVN 2 stated the residents might have dizziness, weakness, paleness, and fainting spells. During an interview on 8/7/2025 at 10:27 a.m. with the Director of Nursing (DON), the DON stated the nurse should have checked Resident 38 and 40's vital signs (measurable physiological indicators that reflected a person's basic bodily functions and overall health status) prior to medication administration within a reasonable time frame of 15-30 minutes. The DON stated it was common nursing practice because the residents' blood pressure

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide necessary gastrostomy tube (GT- a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) services for one of nine residents (Resident 47) when, Licensed Vocational Nurse (LVN) 1 did not flush the GT line with the prescribed amount of water before and after medication administration. This deficient practice had the potential to result in Resident 47's GT clogging (blocked), which may lead to Residents 47 not receiving the full dose of medication or feeding as prescribed. Findings: During a review of Resident 47's admission Record, the admission record indicated Resident 47 was originally admitted to the facility on [DATE]. Resident 47's diagnoses included gastrostomy (GT, a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), and dementia (a progressive state of decline in mental abilities). During a review of Resident 47's Minimum Data Set (MDS- a resident assessment tool), dated 7/2/2025, the MDS indicated Resident 47's cognitive (the ability to think and process information) skills for daily decision making were severely impaired. The MDS indicated Resident 47 was dependent (helper did all the effort) on staff for self-care activities and mobility. During a review of Resident 47's History and Physical (H&P), dated 6/13/2025, the H&P indicated Resident 47 did not have the capacity to understand and make decisions. During a review of Resident 47's care plan titled Altered Nutritional Intake, revised 7/2025, the care plan goal indicated Resident 47 would have adequate nutritional intake with no evidence of weight loss and dehydration daily. The care plan interventions indicated nurses were to provide fluids via GT as ordered. During a medication pass observation on 8/5/2025 at 8:48 a.m. with Licensed Vocational Nurse (LVN) 1, in Resident 47's room, LVN 1 flushed 30 milliliters (mL- a unit of volume in the metric system) of water that flowed through Resident 47's GT by gravity (no pushing). LVN 1 then administered one crushed medication and three liquid medications to Resident 47 via the GT. Once complete, LVN 1 flushed another 30 ml of water. During a concurrent interview and record review on 8/5/2025 at 2:26 p.m. with LVN 1, Resident 47's Physician Order Report for 7/2025 was reviewed. LVN 1 stated Resident 47's Physician Order Report indicated to flush the GT with 50 ml of water before and after medication administration. LVN 1 stated she flushed 30 ml of water instead of 50 ml as ordered because she was nervous. LVN 1 stated the licensed nurse was responsible for checking the physician orders before flushing to make sure of the correct amount. LVN 1 stated not flushing the prescribed amount increased the risks of dehydration and the potential of a clogged GT. During an interview on 8/7/2025 at 10:15 a.m. with the Director of Nursing (DON), the DON stated it was important to follow the physician orders. The DON stated the purpose of flushing water before and after medication administration was to prevent the GT from clogging and not working properly. The DON stated when the GT was not working, it affected the GT patency and the resident's ability to receive the prescribed feeding and/or medications. The DON stated even though the facility policy indicated to flush 30 ml of water before and after the medication administration, the nurse needed to follow the current physician order. During a review of the facility's Job Description for Medication Nurse, undated, the Job Description indicated the medication nurse's responsibilities included performing treatments according to the physician's orders accurately and maintaining an acceptable standard of nursing practice. During a review of the facility's Policy and Procedure (P&P), titled Comprehensive resident centered care plan, undated, the P&P indicated it is the policy of the facility to promote seamless interdisciplinary care for our residents by utilizing the interdisciplinary plan of care based on assessment, planning, treatment, service and intervention.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055856	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
High Valley Lodge	7912 Topley Lane Sunland, CA 91040

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 0805 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 prepare and serve food to meet individual needs for two out of ten sampled residents (Resident 27 and 45) by failing to ensure Residents 27 and 45 received the correct food texture. This deficient practice did not meet Residents' 27 and 45 individual needs and potentially placed Residents 27 and 45 at risk for choking.Findings: 1. During a review of Resident 27's admission Record, the admission Record indicated Resident 27 was originally admitted to the facility on [DATE] and was readmitted on [DATE]. Resident 27's diagnoses included diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing) and pneumonia (an infection/inflammation in the lungs). During a review of Resident 27's History and Physical (H&P) dated 6/23/2025, the H&P indicated Resident 27 was confused. During a review of Resident 27's Minimum Data Set (MDS, a resident assessment tool), dated 2/25/2025, the MDS indicated Resident 27's cognitive skills (ability to think and reason) for daily decision making was severely impaired. The MDS indicated Resident 27 required moderate assistance (helper does less than half the effort) for eating. The MDS indicated Resident 27 was dependent on staff for oral hygiene, toileting hygiene, shower/bathing, dressing, and personal hygiene. The MDS indicated Resident 27 required a mechanically altered diet (modifying the texture of food to make it easier to chew and swallow). During a review of Resident 27's Care Plan for Nutrition related to swallowing and chewing deficit, dated 8/2025, the care plan indicated the goal was for Resident 27 not to have signs of aspiration (the inhalation of food, fluid, or other foreign material into the trachea and lungs) or choking. The care plan interventions indicated to provide a puree texture diet (foods that are blended, mashed, or whipped into a smooth, pudding-like consistency, free of lumps and requiring no chewing) as ordered. During an interview on 8/6/2025 at 8:04 a.m. with Certified Nursing Assistant (CNA) 3, CNA 3 stated Resident 27 was to receive a puree diet. CNA 3 stated a pureed diet was not regular textured food, it was food in a liquid consistency (thickness or texture). CNA 3 stated it was important to serve the correct food texture to residents for their safety. CNA 3 stated Resident 27 could potentially choke when eating if the food was not pureed. During a concurrent observation and interview on 8/6/2025 at 8:12 a.m. with CNA 4, observed Resident 27's meal tray. The meal tray consisted of scrambled eggs and pieces of mushy (soft) bread. CNA 4 stated Resident 27's eggs were scrambled. CNA 4 stated puree food was a smooth consistency where residents did not have to chew. During an interview on 8/6/202 at 10:38 a.m. with the Dietary Supervisor (DS), the DS stated during the meal tray line, the dietary staff must check if the correct food and texture was served to the residents. The DS stated on 8/6/2025, Resident 27 did not receive pureed eggs and bread. The DS stated Resident 27 had an order for a puree diet but was not served a puree diet for breakfast. The DS stated it was important for residents to receive their food in a pureed texture because the residents did not have teeth or had swallowing problems. During a concurrent observation and interview on 8/7/2025 at 7:42 a.m. with CNA 4, Resident 27's meal tray was observed. The meal tray consisted of ground (food that has been finely chopped or minced into small pieces) scrambled eggs and bread. CNA 4 stated Resident 27's eggs were grounded to small pieces. CNA 4 stated Resident 27's food always had the same texture and was never pureed. CNA 4 stated she added milk to Resident 27's food to make the food more liquidy (food that has been processed into a liquid or near-liquid state). CNA 4 stated she smashed up the food with a spoon to make it softer to feed Resident 27. CNA 4 stated food should come out of the kitchen in a puree texture in order to safely feed Resident 27. During an interview on 8/7/2025 at 11:23 a.m. with the DS, the DS stated Resident 27 was ordered a puree diet. The DS stated pureed food was food cut in pieces and somewhat liquified. the DS stated residents with swallowing problems,chewing problems and/or missing teeth required a pureed diet so they could safely eat. The DS stated if residents did not receive pureed food they could potentially choke. 2. During a review of Resident 45's admission Record, the admission Record indicated Resident 45 was originally admitted to the facility on [DATE] and was readmitted on [DATE]. Resident 45's diagnoses included dysphagia (difficulty swallowing) and quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury). During a review of Resident 45's H&P dated 7/18/2025, the H&P indicated Resident 45 did not have the capacity to understand and make decisions. During a review of Resident 45's MDS, dated [DATE], the MDS indicated Resident 45's cognitive skills for daily decision making was intact. The MDS indicated Resident 45 was dependent on staff for all activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and

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	055856	A. Building B. Wing	08/07/2025

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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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. (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 0806 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 prepare and serve food to meet the individualized needs for three out of ten sampled residents (Resident 20, Resident 27, and Resident 45) by failing to: 1. Honor Resident 20's food preferences. 2. Serve Residents 27 and 45 the same food items as other residents. These deficient practices did not meet Resident 20, 27, and 45's individual needs and had the potential to impact the resident's nutritional intake. Findings: 1. During a review of Resident 20's admission Record, the admission Record indicated Resident 20 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 20's diagnoses included muscle wasting (the loss or decrease in muscle mass), atrophy (wasting away or decrease in the size of a body part), and scoliosis (abnormal sideways curvature of the spine). During a review of Resident 20's History and Physical (H&P) dated 7/14/2025, the H&P indicated Resident 20 was oriented to person, place and time. The H&P indicated Resident 20's thought process was coherent and insight was good. The H&P indicated Resident 20's higher cognitive (ability to think and reason) functions were intact. During a review of Resident 20's Minimum Data Set ([MDS] a resident assessment tool), the MDS indicated Resident 20's cognitive skills for daily decision making was intact. The MDS indicated Resident 20 was dependent (helper does all of the effort) on staff for toileting hygiene, lower body dressing, and shower/bathing. The MDS indicated Resident 20 required maximal assistance (helper does more than half) for personal hygiene and upper body dressing. The MDS indicated Resident 20 required assistance for eating and oral hygiene. The MDS indicated Resident 20 required a mechanically altered diet (modifying the texture of food to make it easier to chew and swallow). During an observation on 8/6/2025 at 7:59 a.m., Resident 20's meal tray was observed. The meal tray consisted of bacon. The meal tray was uneaten. During a concurrent observation and interview on 8/6/2025 at 8:12 a.m. with Certified Nursing Assistant (CNA) 4, Resident 20's dietary card indicated Resident 20 was not to be served meat. CNA 4 stated Resident 20 usually received meat for breakfast. CNA 4 stated she did not know why Resident 20 was not supposed to receive meat. During an interview on 8/6/202 at 10:38 a.m. with the Dietary Supervisor (DS), the DS stated a dietary card indicated residents' diet, food texture, likes and dislikes. The DS stated if residents received food they did not like, that was not following the resident's food preferences. The DS stated if a food dislike was written on the resident's dietary card, the resident should not receive that food item. The DS stated she was not aware Resident 20 received bacon that morning (8/6/2025). The DS stated it was not appropriate for Resident 20 to receive bacon because she did not like meat. During an interview on 8/6/2025 at 12:47 p.m. with Resident 20, Resident 20 stated she did not eat her breakfast because it had bacon. Resident 20 stated she told dietary staff she did not want any meat as part of her meals but the staff continued to serve her meat. Resident 20 stated when she received meat, she did not eat her meal. Resident 20 stated she did not want meat for her meals because she could not chew the meat. Resident 20 stated she had broken and missing teeth and it made it hard for her to chew. Resident 20 stated she did not want her teeth to be pulled and did not want to wear dentures. 2. During a review of Resident 27's admission Record, the admission Record indicated Resident 27 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 27's diagnoses included diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing) and pneumonia (an infection/inflammation in the lungs). During a review of Resident 27's H&P dated 6/23/2025, the H&P indicated Resident 27 was confused. During a review of Resident 27's MDS, dated [DATE], the MDS indicated Resident 27's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 27 required moderate assistance (helper does less than half the effort) for eating. The MDS indicated Resident 27 was dependent on staff for oral hygiene, toileting hygiene, shower/bathing, dressing, and personal hygiene. The MDS indicated Resident 27 required a mechanically altered diet. During observations on 8/6/2025 at 7:49 a.m., and 8/7/2025 at 7:42 a.m., Resident 27's meal trays were observed. The meal trays consisted of scrambled eggs and bread. During an interview on 8/7/2025 at 11:23 a.m. with the DS, the DS stated all residents were served a vegetable omelet for breakfast (8/7/2025). The DS stated all residents received the same food unless a resident requested something different. The DS stated residents on a puree diet (foods that are blended, mashed, or whipped into a smooth, pudding-like consistency, free of lumps and requiring no chewing) should have also received a vegetable omelet. The DS stated she did not know Resident 27 did not receive the same food as the other residents. The DS stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055856	A. Building B. Wing	08/07/2025

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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. Based on observation, interview, and record review, the facility failed to ensure plastic containers of canned fruit stored in the refrigerator were labeled and dated. This deficient practice had the potential to result in improper food safety practices and could lead to possible food-borne illness (a disease caused by consuming food or drinks that are contaminated by germs or chemicals) for 45 of 47 residents who received food from the kitchen.Findings: During a concurrent observation and interview on 8/4/2025 at 8:30 a.m., with the Dietary Supervisor (DS), in the kitchen, observed four large-sized plastic containers, dated 7/30/2025, of canned fruit. The containers of fruit had no use-by date. The DS stated the canned fruit was prepared to substitute dessert or fresh fruit during lunch. The DS stated the fruit should be consumed within three days of preparation to maintain quality and safety. The DS stated the fruit exceeded the three-day period, was not labeled with a use-by date and should have been discarded. The DS stated storing prepared food items without proper labeling and timely disposal increased the risk for bacterial growth, spoilage, and a potential for serving unsafe food to residents, which could result in foodborne illness. During a review of the facility's policy and procedures (P&P) titled Labeling and Dating of Foods, undated, the P&P indicated all food items in the refrigerator would be labeled with an open date and used by date.

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	055856	A. Building B. Wing	08/07/2025

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. (continued on next page)

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	055856	A. Building B. Wing	08/07/2025

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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 0813 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 label and properly store food brought by family/ visitors for one out of nine residents (Resident 44), in accordance with the facility's Policy and Procedure (P&P) titled, Foods brought in by family/ visitors. This deficient practice had the potential to result in food borne illnesses (any illness resulting from eating contaminated/spoiled foods) and also lead to other serious medical complications and hospitalization for Resident 44. Findings:During a review of Resident 44's admission Record, the admission record indicated Resident 44 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 44's diagnoses included anemia (a condition where the body did not have enough healthy red blood cells) and ulcerative pancolitis (a chronic inflammatory bowel disease). During a review of Resident 44's Minimum Data Set (MDS - a resident assessment tool), dated 6/7/2025, the MDS indicated Resident 44's cognition (ability to think, remember, and reason) was intact. The MDS indicated Resident 44 required setup assistance from staff with eating. The MDS indicated Resident 44 required supervision from staff with oral hygiene, toileting hygiene, personal hygiene, bed-to-chair transferring, and walking. The MDS indicated Resident 44 required maximal assistance (helper did more than half the effort) from staff with showering/ bathing. During a concurrent observation and interview on 8/4/2025 at 10:40 a.m., in Resident 44's room, observed an unlabeled, opened ketchup bottle at the bedside. The ketchup bottle indicated Refrigerate after opening. Resident stated she opened the ketchup bottle a few weeks ago and puts ketchup on everything. During a concurrent observations and interview on 8/5/2025 at 8:11 a.m. and 8/6/2025 at 8:23 a.m., with Resident 44, in Resident 44's room, observed an unlabeled, opened ketchup bottle, and an unlabeled, opened jar of red raspberry preserves at the bedside. Both food labels indicated to Refrigerate after opening. Resident 44 stated the jar of red raspberry preserves was brought in by her family member. Resident 44 stated she opened the jar a few weeks ago. Resident 44 stated the staff did not offer to store the opened items in the refrigerator. During a concurrent interview and pictures review on 8/6/2025 at 8:26 a.m. with Certified Nursing Assistant (CNA) 1, pictures of Resident 44's unlabeled and opened ketchup bottle and jar of red raspberry preserves, dated 8/6/2025 at 8:23 a.m., were reviewed. CNA 1 stated the pictures showed the unlabeled and opened ketchup bottle and jar of red raspberry preserves at Resident 44's bedside. CNA 1 stated both food items indicated to Refrigerate after opening. CNA 1 stated the charge nurse should label the date the items were received, the resident's name, and room number. CNA 1 stated the purpose of labeling outside food was to identify the ownership and to indicate expiration dates for items that were only to be kept for a limited number of days. CNA 1 stated Resident 44's outside food needed to be stored in the refrigerator to prevent Resident 44 from getting sick. CNA 1 stated the inappropriate food storage could cause foodborne illness among residents. During a concurrent interview and pictures review on 8/6/2025 at 8:38 a.m. with the Infection Preventionist Nurse (IPN), pictures of Resident 44's unlabeled and opened ketchup bottle and jar of red raspberry preserves, dated 8/4/2025 at 10:40 a.m., 8/5/2025 at 8:11 a.m., and 8/6/2025 at 8:23 a.m., were reviewed. The IPN stated the pictures showed the unlabeled and opened ketchup bottle and jar of red raspberry preserves at Resident 44's bedside. The IPN stated both food items indicated to Refrigerate after opening. The IPN stated the items should be stored in the refrigerator if the label indicated so, to prevent food from spoiling. The IPN stated the residents might get sick from eating the spoiled food. The IPN stated the residents might experience signs and symptoms such as diarrhea, abdominal pain, and nausea/vomiting. The IPN stated staff who had the most contact with the residents should ensure the outside food was stored properly. During a review of the facility's P&P titled, Foods brought in by family/ visitors, revised on 12/2008, the P&P indicated Perishable foods must be stored in re-sealable containers with tightly fitting lids in the refrigerator. Containers will be labeled with the resident's name, the item and the 'use by' date. The nursing staff is responsible for discarding perishable foods on or before the ‘use by' date.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on interview and record review, the facility failed to ensure the Infection Preventionist (IP) completed ten hours of continuing Infection Prevention and Control education on an annual basis. This failure had the potential for the IP to be unaware and be unable to educate the facility's staff of updated information regarding Infection Prevention and Control practices.Findings:During an interview on 8/6/2025 at 10:30 a.m., with the facility's Infection Preventionist (IP), the IP stated he was not able to provide documentation indicating the completion of ten hours of continuing education in infection prevention and control for 2024. The IP stated he completed continuing education hours when he renewed his nursing license, however, those hours were not obtained in 2024. The IP stated it was his responsibility to complete ten hours of infection prevention and control education annually to ensure he was aware of any new guidelines or studies that were released and to be up to date with current infection prevention and control practices. During an interview on 8/7/2025 at 8:58 a.m., with the Director of Nursing (DON), the DON stated the IP was responsible for educating staff on current infection prevention and control practices. The DON stated for the IP to effectively educate staff, he must remain current on infection prevention and control updates. The DON stated that failure to complete the required annual ten hours of training could result in the IP missing critical changes in infection control practices, which could lead to inconsistent implementation of current infection prevention measures.A review of the California Department of Public Health All Facilities Letter (AFL), dated 11/4/2020, the AFL indicated, The IP should complete 10 hours of continuing education in the field of [Infection Prevention and Control] on an annual basis. Facilities should provide encouragement and support for IP staff to stay abreast of current news and training sources through a nationally recognized infection prevention and control association.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. During an observation, interview, and record review, the facility failed to meet the required room size measurement of 80 square feet ([sq. ft.]- a unit of measurement) of room space per resident in rooms with multiple residents. This deficient practice could potentially affect the residents privacy, health, and safety. Findings: During a review of the facility's Client accommodations Analysis form, dated 8/4/2025, the form indicated 24 rooms in the facility did not meet the 80 sq. ft. per resident requirement. Room location # of beds Sq. Ft. 1. 1 2 149.38 2. 2 2 149.38 3. 3 2 149.38 4. 4 2 149.38 5. 5 2 149.38 6. 6 4 282.87 7. 7 2 149.38 8. 8 2 149.38 9. 9 2 149.38 10. 10 2 149.38 11. 11 2 149.38 12. 12 2 149.38 13. 13 2 149.38 14. 14 2 149.38 15. 15 2 149.38 16. 16 2 149.38 17. 17 2 152.78 18. 18 2 167.44 19. 19 2 149.38 20. 20 2 149.38 21. 21 2 149.38 22. 22 2 149.38 23. 23 2 149.38 24. 24 2 155.08 The minimum requirement for a 2 bedroom should be at least 160 sq. ft. The minimum requirement for a 4 bedroom should be at least 320 sq. ft. During a review of the facility's Room Waiver Request Letter, dated 4/19/2024, the letter indicated 24 resident rooms (Rooms 1 - 24) did not meet the 80 sq. ft. of space per resident requirement. The letter indicated the facility would ensure wheelchair residents would freely move in and out of their rooms and the room would have space for one chair, a bedside table and one built-in closet. The letter indicated if a resident expressed a concern of room space it would be discussed during an interdisciplinary meeting for proper intervention. During observations made throughout the survey, from 8/4/2025 to 8/7/2025, there were no adverse effects that pertained to the residents' care provided by facility staff, residents' privacy, health, and safety related to the provided living space of less than 80 sq. ft. per resident. During a concurrent record review and interview, on 8/7/2025, at 1:23 p.m., with the Administrator (Admin), the facility's Room Waiver Request, dated 9/11/2024, was reviewed. The request indicated the lack of space based on new building code had no adverse effect in the health, safety, or in maintaining the well-being of the residents. The ADM stated the facility would ensure the residents' needs were met and residents' health and safety were not adversely affected. During a review of the facility's Policy and Procedure (P&P) titled Use of Resident Bedrooms Under 80 Square Feet, dated 4/30/2025, the P&P indicated it was the facility's purpose to ensure resident rooms measuring less than 80 square feet per resident are used only when allowed under state or federal grandfathering provisions, and that such rooms are safe, functional, and in compliance with resident rights and comfort standards. The Department will recommend the request for a waiver/variance.