

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055856	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2026
NAME OF PROVIDER OR SUPPLIER High Valley Lodge		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program when: 1. One of one inspected medication carts (Medication Cart South) contained a package of syringes with an expiration date of [DATE]. 2. The facility's water management plan was out of date and not implemented as written. These failures had the potential to increase the risk of transmission of infectious microorganisms and waterborne illness to all residents in the facility. Findings: 1. During a concurrent observation and interview on [DATE] at 1:32 p.m., with the Minimum Data Set Coordinator (MDSC), at Medication Cart South, observed a package of syringes in a medication cart drawer. The syringe packaging indicated an expiration date of [DATE]. The MDSC stated she didn't know why the syringes were in the cart. The MDSC stated if they were ever used on a resident the quality of the syringes could be affected since they were marked as expired. During an interview on [DATE] at 2:52 p.m., with the Director of Nursing (DON), the DON stated since the syringes were expired this could affect their quality, they could be damaged, and the sterility (the freedom from the presence of contaminants and microorganisms) could be affected. During a review of the facility's policy and procedure (P&P) titled, Medical Supply Storage, last reviewed [DATE], the P&P indicated medical supplies are stored in a safe, clean, organized, and secure manner to maintain product integrity and prevent contamination. The P&P further indicated staff shall routinely inspect supplies for expiration dates and package integrity. The P&P indicated expired, damaged, wet, opened, or contaminated supplies shall be removed from stock immediately and disposed of according to facility procedures. 2. During a concurrent interview and record review on [DATE] at 4:14 p.m., with the Director of Staff Development (DSD), reviewed the facility's Water Management Plan, dated [DATE]. The section titled, Section 2. Personnel Roles and Responsibilities, indicated the DSD was in charge with the function of infection control. The DSD stated in 2018 he had been in that position, but now the Infection Preventionist (IP) was the person in charge of that role. The DSD stated the individual listed as the maintenance program administrator no longer worked in the facility and was no longer involved with the water management plan. The DSD stated the people listed as the clinical representative and laboratory contact had also changed. During a concurrent interview and record review on [DATE] at 10:00 a.m., with the Maintenance Supervisor (MS), reviewed the Water Temperature Log. The Water Temperature Log indicated water temperature monitoring was completed in resident rooms and showers. The MS stated she checks water temperatures in resident room sinks and showers weekly as a part of the water management plan. The MS stated there were no other areas she monitored the water temperature in the facility. During a concurrent interview and record review on [DATE] at 1:12 p.m., with the IP, reviewed the facility's Water Management Plan, dated [DATE]. The section titled, Section 5. Potable Water System Monitoring, indicated the following control point designations to be monitored weekly: CWS-1, HWS-1, and HWS-2 and referred (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 055856
		If continuation sheet Page 1 of 24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055856	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2026
NAME OF PROVIDER OR SUPPLIER High Valley Lodge		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	to a piping and instrumentation diagram (P&ID, a schematic which shows piping, instruments, and control systems). The IP could not provide information on the monitoring of these control points or the P&ID. The IP stated the Water Management Plan should be updated since it was last updated in 2018 and the people involved with water management in the facility have changed. The IP stated the Water Management Plan is important to maintain the safety of the residents. The IP stated if the Water Management Plan is not up to date and implemented correctly there is a potential of increased risk of the growth of bacteria like legionella (bacteria found in freshwater environments which can cause illness when it multiplies in human-made water systems). During a review of the facility's P&P titled, Infection Prevention and Control Program, last reviewed [DATE], the P&P indicated the Infection Prevention and Control Program includes implementing measures to prevent the transmission of infectious agents and to reduce risks for device and procedure-related infections. During a review of the facility's P&P titled, Water Supply, last reviewed [DATE], the P&P indicated the purpose of the P&P was to maintain a sanitary water supply and control the spread of waterborne microorganisms. The P&P indicated approaches to controlling waterborne microorganisms (i.e. water system decontamination) will be consistent with state and local health department requirements.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055856	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2026
NAME OF PROVIDER OR SUPPLIER High Valley Lodge		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on observation, interview, and record review, the facility failed to ensure residents receive treatment and care in accordance with professional standards of practice for one of one sampled resident (Resident 14) by failing to: 1. Conduct a change of condition (COC- a sudden clinically important deviation from a resident's baseline in physical, cognitive, behavioral, or functional domains), assessment, and monitoring of Resident 14's generalized skin condition. 2. Notify Resident 14's resident representative for the progression of skin condition to the facial area. This failure resulted in insufficient information regarding the resident's wound progression and created the potential for worsening skin condition for Resident 14. Findings: During a review of Resident 14's Face Sheet, the Face Sheet indicated that the facility initially admitted Resident 14 to the facility on 2/1/2024 with diagnoses including hypertension (HTN-high blood pressure), dementia (a progressive state of decline in mental abilities), atopic dermatitis (a skin condition that involves itchy, dry skin or a rash on swollen, reddened skin), and bullous pemphigoid (rare skin condition that causes large fluid filled blisters). During a review of Resident 14's Minimum Data Set (MDS - a resident assessment tool) dated 5/13/2026, the MDS indicated that Resident 14's cognition (mental action or process of acquiring knowledge and understanding) was severely impaired. The MDS indicated Resident 14 was ranging from maximal assistance (helper does more than half the effort) to dependent (helper does all of the effort) for physical assistance from staff for activities of daily living (ADLs - eating, toileting, hygiene, shower/bathing). The MDS also indicated that Resident 14 did not have any ulcer, wound or skin problems. During a review of Resident 14's History and Physical (H&P) dated 5/30/2026, the H&P indicated that Resident 14 did not have the capacity to understand and make decisions. During a review of Resident 14's Dermatology (medical doctor that specializes in the diagnosis, treatment, and prevention of diseases, disorders, and conditions affecting the skin) Institute dated 6/18/2026, the record indicated that Resident 14 had urticarial lesions (skin rash with itchy pink welts), large tense subepidermal (beneath the outer layer of the skin) vesicles (tiny, fluid-filled sac), erosions (destruction of tissue) and denuded surfaces, involving head, neck, chest, abdomen, back, pelvis, upper extremities, lower extremities that are chronic (last longer than months) and moderately worse. During a review of Resident 14's Short term skin integrity care plan dated 4/20/2026, the short term skin integrity care plan indicated that Resident 14 had altered skin integrity related to bullous pemphigoid with interventions such as observation for signs of deterioration in healing process and monitor for signs and symptoms of infections. During a review of Resident 14's records titled, Care Plan, dated 6/17/2026, the care plan indicated that Resident 14 has atopic dermatitis and recurrent bullous pemphigoids. The care plan indicated a goal that Resident 14 will show improvement in atopic dermatitis symptoms as evidenced by decreased redness, inflammation, itching, and skin irritation with interventions such as assessment of any new changes in skin condition including redness, rash (area of the skin that has changes in texture or color and may look inflamed or irritated), dryness, excoriation (damaged skin), open areas, and signs of infection. During a review of Resident 14's Physician Order Report dated 6/29/2026, the physician order report indicated the following physician order: -Left arm bullous pemphigoid- cleanse with normal saline (mixed solution of salt and water), pat dry, apply vitamin A&D ointment (used as moisturizer to treat or prevent rough, flaky, dry itchy skin) with xeroform (non-adherent medical gauze that is soaked with petroleum jelly and a mild antiseptic medication) dressing, wrap with rolled gauze once a day for 21 days. During an observation on 6/29/2026 at 9:43 a.m., with Resident 14, Resident 14 was observed with generalized scab (crusty layer of dried blood that forms over a skin injury) of varying sizes on (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055856	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2026
NAME OF PROVIDER OR SUPPLIER High Valley Lodge		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	her upper chest, neck and hands that are dry and others are open. During a telephone interview on 6/29/2026 at 12:13 p.m., with Family Member 1 (FM 1), FM 1 stated that Resident 14 had a chronic skin condition over several months, with periods of exacerbation. FM 1 indicated that Resident 14 required hospitalization on two occasions due to the worsening of the skin condition. FM 1 further expressed concern regarding the lack of communication from the staff about the progression of the condition to Resident 14's facial area and current state. During a concurrent observation and interview on 7/1/2026 at 11:50 a.m., with Certified Nursing Assistant 3 (CNA 3), observed Resident 14 scratching skin on her right leg and face. CNA 3 reported that Resident 14 frequently scratches herself and has wounds located on the right lateral side of her body, upper arms, lower legs, neck, and lower chin. During a concurrent interview and record review on 7/1/2026 at 11:59 a.m., with Licensed Vocational Nurse 1 (LVN 1), reviewed Resident 14's change of condition and wound management assessment. LVN 1 stated that any changes in skin should prompt a change of condition assessment. However, Resident 14's records did not specify when the skin condition began. LVN 1 indicated that nurses rely on their assessments to determine whether to initiate this process. Additionally, LVN 1 stated that she was unfamiliar with the proper documentation procedure for wound assessments. During a concurrent interview and record review on 7/1/2026 at 12:50 p.m., with the Director of Nursing (DON), reviewed Resident 14's wound management assessment records were reviewed. The DON was unable to provide a nursing assessment completed whether Resident 14's skin condition was improving or deteriorating. The DON defined wounds as ulcers, rashes, or open skin. The DON indicated that there was no record of assessment or monitoring of wound progress, though the DON emphasized these steps are necessary. The DON stated that assessment and ongoing monitoring help determine if the condition is getting better, worsening, or require treatment adjustments to ensure effective care. Furthermore, the DON stated that without proper assessment and monitoring, the wound's status cannot be tracked and may worsen. The DON noted that insufficient monitoring increases the risk of complications such as worsening wounds and possible infection. During a subsequent concurrent interview and record review on 7/1/2026 at 12:50 p.m. with the DON, reviewed Resident 14's change of condition evaluation. The DON stated that any detected skin changes must be monitored for at least 72 hours, require a physician's treatment order, and involve weekly wound documentation along with notifications to both the physician and the resident's representative. The DON stated that the nursing documentation could not specify when Resident 14 first developed a scab or an open wound in the neck or chin area, nor was a change of condition evaluation initiated or that the resident's representative was notified. According to the DON, the resident's representative needs to be informed about any changes in the resident's condition so they can stay updated on care and worsening status. During a review of the facility's Policy and Procedure (P&P) titled, Skin Care, reviewed 2/18/2026, the P&P indicated that the unit nurse is responsible for assessing a resident's skin upon admission and promptly initiating care planning for any individual identified as being at risk for pressure ulcers. A comprehensive head-to-toe skin assessment must be conducted during each scheduled evaluation and anytime there is a significant change in condition, including consideration of risk factors such as steroid use (which may impair wound healing), history of skin breakdown, and impaired mobility. The unit nurse is required to complete scheduled head-to-toe skin inspections, notify the physician if there is any deterioration in skin integrity, and document findings weekly in the resident's record, in the monthly summary, and after every skin inspection, treatment, or dressing change. Documentation should include the status of the resident's skin and detailed information about any areas of skin breakdown, including measurements (width, length, depth), tissue type, and presence of exudate. Staff are expected to recognize and report signs of skin breakdown, which may (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055856	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2026
NAME OF PROVIDER OR SUPPLIER High Valley Lodge		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	include purple or darkened areas, edema, induration, erythema, or bogginess. During a review of facility's P&P titled, Wound Management, reviewed 2/18/2026, the P&P indicated that the purpose of this program is to support the facility in providing care, services, and documentation related to the occurrence, treatment, and prevention of both pressure and non-pressure wounds. Upon admission, all residents will undergo a Braden scale (tool used to evaluate a patient's risk of developing pressure ulcers) assessment, which will also be completed during each quarterly and annual evaluation, following any significant change assessment, and as determined necessary by the interdisciplinary team. This process includes the identification and management of newly developed pressure ulcers. During a review of facility's P&P titled, Change of Condition, reviewed 2/18/2026, the P&P indicated that except in medical emergencies, the facility will notify the resident, their attending physician, and any interested family member or legal representative regarding changes in the resident's condition or status. The licensed nurse responsible for the resident's care is charged with promptly notifying the resident (as applicable), the primary care physician, family members, and/or legal representatives of any change in the resident's status or condition. Examples include incidents or accidents involving the resident resulting in injury or those potentially requiring physician intervention; significant improvements or declines in physical, mental, or emotional status, especially in life-threatening situations or clinical complications; and any substantial alteration to treatment plans. Notifications must be made as soon as practicable, typically within minutes or hours after the discovery of the change in condition, depending on its nature-and, in all circumstances, no later than twenty-four hours from such discovery. All changes in the resident's medical condition must be thoroughly documented in the resident's medical records according to established charting and documentation policies and procedures. Notification of the resident, primary care physician, legal representative, or family member must also be properly recorded in the resident's medical records.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055856	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2026
NAME OF PROVIDER OR SUPPLIER High Valley Lodge		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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 safe and sanitary food storage and food preparation practices in the kitchen when: 1. In reach-in refrigerator 1, one container of non-dairy creamer and a chocolate-flavored syrup did not have an open date label. 2. In reach-in refrigerator 2, a bag of corn tortillas did not have an open date label. There was an opened bag of flour tortillas, a storage bag containing an opened bag of shredded cheese, and a container bottle of sliced dill pickles-left open and not properly sealed. There was one bottle of salad dressing found expired on 6/20/2026. 3. On the storage rack, there were no open date labels on containers of beef flavor soup base, tarragon leaves, ground cinnamon powder, poultry seasoning, cocoa powder, chicken flavor soup base, ground rosemary, and ground cumin. And a container of cayenne pepper powder was found to be expired on 5/20/2026. 4. There were six chopping boards that had staining and knife scratches. These failures have the potential to result in harmful bacterial growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness (a disease caused by consuming food or drinks that are contaminated by germs or chemicals) affecting 44 of 45 medically compromised residents who received food from the kitchen. Findings: During a concurrent observation and interview on 6/29/2026 at 7:51 a.m., with the Dietary Supervisor (DS), observed reach in refrigerator 1, reach in refrigerator 2, and storage rack with the following: - In reach-in refrigerator 1, one opened container of non-dairy creamer and a chocolate-flavored syrup did not indicate an open date. - In reach-in refrigerator 2, an opened bag of corn tortillas did not have an open date label. Additionally, there was an opened bag of flour tortillas, a storage bag containing opened bag of shredded cheese, and a container of sliced dill pickles-all left open and not properly sealed. One container of salad dressing was found expired on 6/20/2026. - On the storage rack, there were no open date labels on containers of beef flavor soup base, tarragon leaves, ground cinnamon, poultry seasoning, cocoa powder, chicken flavor soup base, ground rosemary, and ground cumin. A container of cayenne pepper was found to be expired as of 5/20/2026. The DS stated that for proper food storage, staff are expected to label any opened items with the date they were initially opened to ensure timely disposal, thereby maintaining quality standards of each food item. The DS stated that expired food items must not be kept in the kitchen and are required to be discarded promptly, as expired products may compromise the quality of the food. Additionally, the DS stated that all opened food items must remain properly sealed to preserve freshness and reduce the risk of foodborne illness among residents. The DS further stated that when storing items in bags, staff must ensure they are securely always sealed. During a concurrent observation and interview on 6/30/2026 at 12:20 p.m., with the DS, observed six differently colored chopping boards exhibited staining and knife marks. The DS stated that the chopping boards were old and required replacement to prevent cross-contamination. Furthermore, the DS stated that the chopping boards could no longer be adequately cleaned, presenting a potential risk for bacterial growth. During a review of facility's Policy and Procedures (P&P) titled, Labeling and Dating of Foods, reviewed 2/18/2026, the P&P indicated that all food items stored in the storeroom, refrigerator, and freezer must be appropriately labeled and dated. Newly opened food items are required to be securely closed, labeled with the date of opening, and consumed by the date specified in accordance with relevant storage guidelines, including Dry Goods Storage Guidelines, Refrigerated Storage Guidelines, Produce Storage Guidelines, and Freezer Storage Guidelines. During a review of facility's P&P titled, Sanitation, reviewed on 2/18/2026, the P&P indicated that the Food & Nutrition Services Department is required to possess (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055856	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2026
NAME OF PROVIDER OR SUPPLIER High Valley Lodge		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	equipment suitable in type and sufficient in quantity for proper food preparation, serving, and storage. Adequate equipment must also be available for cleaning, waste disposal, and general storage purposes. All equipment shall be maintained as needed and kept in optimal working conditions. Utensils, counters, shelves, and other equipment must be kept clean, well-maintained, and free from breaks, corrosion, open seams, cracks, and chipped areas. Separate chopping boards are designated for the preparation of meats and vegetables; following each use, these boards must be thoroughly cleaned and sanitized.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055856	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2026
NAME OF PROVIDER OR SUPPLIER High Valley Lodge		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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 of garbage and refuse properly when: 1. Two dumpsters (a movable waste container designed to be brought and taken away by special collection vehicles, or to a bin that specially designed garbage truck lifts) bodies were not free of rust, dirt and dried liquid spills. 2. The black-colored dumpster had a cluster of ants. 3. Two dumpsters were not completely covered when it had a gap under the lids exposing garbage when not in use. 4. The blue-colored dumpster had overflowing with garbage and not completely closed when not in use. These failures attracted ants and have the potential to attract other pests (animals or microorganisms that have a negative effect on humans) such as rats, cockroaches, and flies, which may spread infection to 45 out of 45 residents living in the facility. Findings: During an interview on 6/30/2026 at 8:34 a.m., with the Dietary Supervisor (DS), the DS stated that kitchen and food item garbage was collected by housekeeping staff after each meal and disposed of in the outside dumpster area. During a concurrent observation and interview on 6/30/2026 at 9:04 a.m., with the Maintenance Supervisor (MS), observed the dumpster outside of the facility with the following: -The two dumpsters (black and blue colored) bodies had rust, dirt and dried liquid spills. -The black colored dumpster had a cluster of ants crawling on the right side of the dumpster. -The two dumpsters cover had three inches gap, and the lid not tightly covered that exposed garbage when it was not used. -The blue dumpster had overflowing garbage and not completely closed when not in use. The MS stated that housekeeping staff removes the garbage as needed and places it in the dumpster throughout the day. According to the MS, she did not know who was maintaining the cleanliness of the dumpster and the company responsible for garbage collection was responsible in ensuring the dumpster is properly sealed and kept clean. The MS also stated there is a gap of at least three inches in both dumpsters, which could potentially attract insects and pests. The MS further stated that the garbage cover should remain closed and always sealed to prevent attraction of insects and pests. During a subsequent interview on 7/1/2026 at 11:44 a.m., with the MS, the MS stated that the dumpster should be replaced, emphasizing the importance of keeping the dumpsters clean and always closed to prevent pests and other animals from accessing it, thereby reducing the risk of spreading infection. During a review of facility's Policy and Procedures (P&P) titled, Food-Related Garbage and Rubbish Disposal, reviewed 2/18/2026, the P&P indicated the following guidelines: All garbage and rubbish containers must have tight-fitting lids or covers and should remain covered when stored or not in continuous use. Housekeeping staff are responsible for emptying these containers daily, cleaning their exteriors at least once a day, and cleaning the interiors at least once a week, all while ensuring food, equipment, utensils, or food preparation areas are not contaminated during the process. Food waste-containing garbage and rubbish must be stored so that vermin cannot access it. Storage areas are required to stay clean at all times and not become a nuisance. Outside dumpsters provided by garbage collection services must be kept closed and free from surrounding litter. During a review of facility's P&P titled, Pest Control, reviewed 2/18/2026, the P&P indicated that the facility implements a continuous pest control program aimed at maintaining the premises free from insects and rodents. Additionally, garbage and trash are not allowed to accumulate and are removed from the facility on a daily basis.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055856	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2026
NAME OF PROVIDER OR SUPPLIER High Valley Lodge		STREET ADDRESS, CITY, STATE, ZIP CODE 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide care in a manner that promoted resident dignity and respect for one of five residents (Resident 6) observed during the medication administration facility task when the Minimum Data Set Coordinator (MDSC) failed to completely close Resident 6's privacy curtain during medication administration. This failure violated the resident's right to be treated with respect and dignity and had the potential to negatively affect resident's sense of self-worth and self-esteem. Findings: During a review of Resident 6's Face Sheet (the front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated the facility originally admitted Resident 6 on 3/27/2022 and re-admitted on [DATE] with diagnoses including pneumonia (infection of the lungs), chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing) and muscle contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion) of the left and right upper arm. During a review of Resident 6's Minimum Data Set (MDS -a resident assessment tool) dated 6/11/2026, the MDS indicated Resident 6 has no speech (absence of spoken words). The MDS indicated Resident 6's cognitive (ability to learn, think, make decisions, and remember) skills were severely impaired. During review of Resident 6's History and Physical (H&P) dated 7/16/2025, the H&P indicated Resident 6 cannot make own medical decisions but can make needs known. During the medication pass observation on 6/30/2026 at 8:56 a.m., observed the MDSC draw Resident 6's privacy curtain only halfway along the length of the bed, leaving the lower portion of the resident's body visible. The MDSC removed the blanket covering Resident 6's abdomen and lifted Resident 6's gown to access Resident 6's gastrostomy tube (g-tube - flexible device inserted through the abdomen directly into the stomach to deliver nutrition, fluids, and medications) to administer medications, exposing the resident's abdomen. During an interview on 6/30/2026 at 9:15 a.m. with MDSC, the MDSC stated that the privacy curtain should have been drawn all the way, leaving no gaps, to ensure Resident 6's privacy during g-tube medication administration. The MDSC stated that leaving the privacy curtain partially open did not prevent others from being able to see Resident 6 while receiving medication. The MDSC stated that privacy should always be provided during medication administration, and especially when medication is being administered via g-tube where body parts get exposed. The MDSC stated not having the privacy curtain completely drawn could have resulted in unnecessary exposure of Resident 6's body to Resident 6's roommate or anyone entering Resident 6's room, compromising Resident 6's dignity. During an interview of 7/2/2026 at 8:41 a.m. with the Director of Nursing (DON), the DON stated that privacy curtains are used during treatments, such as medication administration, to protect residents' privacy and dignity. The DON stated that maintaining privacy and avoiding unnecessary exposure is essential for supporting residents' dignity. The DON stated that violating resident's right to privacy can negatively impact residents' dignity and overall well-being. During a review of the facility's policy and procedure (P&P) titled, Resident Privacy during Care and Treatment, last reviewed 2/18/2026, the P&P indicated, To protect each resident's right to privacy, dignity, and respect during the provision of care, treatments, and personal services, the facility is committed to maintaining resident privacy during all treatments, examinations, personal care, and clinical procedures. Staff shall take reasonable measures to prevent unnecessary exposure of a resident's body and protect the resident from being viewed by others not involved in their care. Privacy curtains, doors, or screens shall be closed before beginning any treatment or personal care that may expose the resident.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055856	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2026
NAME OF PROVIDER OR SUPPLIER High Valley Lodge		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one of five residents (Resident 6) observed during medication administration was informed of the indication (reason for the use) of the medications prior to administration of the medications. This deficient practice violated Resident 6's right to be informed in advance of the treatment being provided. Findings: During a review of Resident 6's Face Sheet (the front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated the facility originally admitted Resident 6 on 3/27/2022 and re-admitted on [DATE] with diagnoses including pneumonia (infection of the lungs), chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing) and muscle contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion) of the left and right upper arm. During a review of Resident 6's Minimum Data Set (MDS -a resident assessment tool) dated 6/11/2026, the MDS indicated Resident 6 has no speech (absence of spoken words). The MDS indicated Resident 6's cognitive (ability to learn, think, make decisions, and remember) skills were severely impaired. During review of Resident 6's History and Physical (H&P) dated 7/16/2025, the H&P indicated Resident 6 cannot make own medical decisions but can make needs known. During medication pass observation on 6/30/2026 at 8:56 a.m., observed Minimum Data Set Coordinator (MDSC) administer aspirin (medication used to relieve mild to moderate pain and to prevent blood clots) 81 milligrams (mg - unit of measure) and polyethylene glycol (medication used to treat constipation) 3350 powder; 17 grams (gm-unit of measurement) dose. The MDSC was observed not informing Resident 6 of the indication for each medication prior to administration. During an interview on 6/30/2026 at 9:15 a.m. with the MDSC, the MDSC stated it is her responsibility to inform Resident 6 of the indication for each medication prior to its administration. The MDSC stated she forgot to do so prior to administering Resident 6's medications. The MDSC stated it is important to always inform residents of the indication for the medication they are about to receive as it is the resident's right to know the treatment being given to them, and that medications are part of the resident's treatment. The MDSC stated all residents need to be fully informed of the medication they are receiving, regardless of their cognitive (ability to learn, think, make decisions, and remember) function. During an interview on 7/2/2026 at 8:41 a.m. with the Director of Nursing (DON), the DON stated that residents must be fully informed about any medications they are prescribed. The DON stated that before each administration, the licensed nurse giving the medication is required to tell the residents both the name of the medication and the reason it is prescribed. The DON stated informing the residents of the medication helps residents understand its intended benefits. The DON stated that if a resident is not informed of the reason for use of the medication, they may refuse it. When residents are informed of the indication for the medication, it lets them know how it will help them, which eliminates refusal of medication that is due to residents not knowing why a medication is being given to them. The DON stated that all residents must be informed prior to receiving medication, regardless of their condition, as it is every resident's right to be informed about all treatments, medications and care they receive. The DON stated that it is inappropriate to assume that there are certain residents who cannot understand. The DON stated Resident 6 should have been informed of the indication for the medication before administration. During a review of Resident 6's Physician Order Report (POR), dated 7/1/2026-7/31/2026, the POR indicated an order for aspirin tablet; 81 mg, a tab; gastric tube; once a day for clot prevention and an order for polyethylene glycol 3350 powder; 17 gm/dose; 1 dose; gastric tube; once a day for bowel management. During a review of the facility's (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055856	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2026
NAME OF PROVIDER OR SUPPLIER High Valley Lodge		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	policy and procedure (P&P) titled, Resident Rights last reviewed 2/18/2026, the P&P indicated, Planning and Implementing Care. You have the right to be informed of, and participate in, your treatment, including the right to: .be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care.be informed in advance, by the physician, or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or options you prefer.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055856	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2026
NAME OF PROVIDER OR SUPPLIER High Valley Lodge		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that a call light (a device used by a resident to signal his or her need for assistance from staff) was within reach for one of 14 sampled residents (Resident 6). This failure had the potential to result in Resident 6 not being able to call for staff assistance and delay in the provision of necessary care and services which could negatively affect the residents' comfort and well-being. Findings: During a review of Resident 6's Face Sheet (the front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated the facility originally admitted Resident 6 on 3/27/2022 and re-admitted on [DATE] with diagnoses including pneumonia (infection of the lungs), chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing) and muscle contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion) of the left and right upper arm. During a review of Resident 6's Minimum Data Set (MDS -a resident assessment tool) dated 6/11/2026, the MDS indicated Resident 6 has no speech (absence of spoken words). The MDS indicated Resident 6's cognitive (ability to learn, think, make decisions, and remember) skills were severely impaired. The MDS indicated Resident 6 was dependent (helper does all of the effort) with activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) and dependent for all mobility functions. During review of Resident 6's History and Physical (H&P) dated 7/16/2025, the H&P indicated Resident 6 cannot make own medical decisions but can make needs known. During a review of Resident 6's care plan (a document that outlines a resident's healthcare needs, goals, and the interventions planned to achieve those goals) titled, ADL/Self Care Deficit initiated 3/12/2026, the care plan indicated the intervention, Have call light within reach and answer promptly. During a concurrent observation and interview on 6/29/2026 at 12:30 p.m. with the Minimum Data Set Coordinator (MDSC), observed Resident 6 lying in bed with the touch pad call light placed approximately a foot away from Resident 6's left side of the face. The MDSC stated that Resident 6 has very limited mobility due to contractures and has the touch pad call light that gets activated by touch instead of needing to press a button. The MDSC stated that for Resident 6, the touch pad call light is supposed to be placed by her elbow since the resident can move her arms and use her elbow to activate the call light as needed. The MDSC stated that Resident 6's call light was not accessible to the resident where it had been placed. The MDSC stated that without the call light placed within Resident 6's reach, Resident 6 is unable to call for assistance or alert staff if potentially feeling unwell or having pain or having any symptoms that calls for attention. During an interview on 7/2/2026 at 8:41 a.m. with the Director of Nursing (DON), the DON stated that call lights are used by residents to alert staff when assistance is needed. The DON stated that call lights must always remain within reach and be responded to promptly. The DON stated that not having accessibility to the call light may cause delay in providing care to the resident or unmet needs. The DON further stated that not having a call light accessible is a safety concern, as it increases the risk of falls among residents who require assistance and may attempt to get out of bed independently or reach for items that are not within their reach. During a review of the facility's policy and procedure (P&P) titled, Answering the Call Light last reviewed 2/18/2026, the P&P indicated, Be sure that call light is plugged in at all times. When the resident is in bed or confirmed to a chair, be sure the call light is within reach of the resident.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055856	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2026
NAME OF PROVIDER OR SUPPLIER High Valley Lodge		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation, interview and record review, the facility failed to ensure the resident was provided with information and assistance to formulate an advance directive (written statement of a person's wishes regarding medical treatment made to ensure those wishes are carried out should the person be unable to communicate them to a doctor) for one of five sampled residents (Resident 2). reviewed under the Advance Directive care area. This failure violated Resident 2's right to be fully informed of the option to formulate their advance directive and had the potential to cause conflict with a resident's wishes regarding health care. Findings: During a review of Resident 2's Face Sheet, the Face Sheet indicated that the facility initially admitted Resident 2 to the facility on 3/06/2026, with diagnoses including type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), chronic systolic heart failure (a condition in which the heart does not pump blood as well as it should), depression(a mood disorder that causes persistent feeling of sadness and loss of interest) and generalized anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety or fear that are strong enough to interfere with one's daily activities). During a review of Resident 2's Minimum Data Set (MDS -a resident assessment tool) dated 3/19/2026, the MDS indicated that Resident 2's cognition (mental action or process of acquiring knowledge and understanding) was intact. The MDS indicated Resident 2 required ranging from set-up assistance (helper assists only prior to or following the activity) to maximal assistance (helper does more than half the effort) for physical assistance from staff for activities of daily living (ADLs - eating, toileting, hygiene, shower/bathing). During a review of Resident 2's Initial History and Physical (H&P) dated 3/7/2026, the H&P indicated that Resident 2 had the capacity to understand and make decisions. During a review of Resident 2's record titled, Advance Directive Acknowledgement dated 3/18/2026, the Advance Directive Acknowledgment indicated that Resident 2 marked I have executed an Advance Directive and I wish to execute an Advance Directive. During a review of Resident 2's Physician Orders for Life-Sustaining Treatment (POLST - a portable medical order form that records patients' treatment wishes so that emergency personnel know what treatments the patient wants in the event of a medical emergency, taking the patient's current medical condition into consideration. A POLST form is not an advance directive.) dated 3/27/2025, the POLST indicated the resident's advance directive was not available. During a concurrent observation and interview on 7/1/2026 at 11:11 a.m. with Resident 2, Resident 2 was awake, alert, oriented to person, place, and time, and able to answer questions while in the wheelchair. Resident 2 stated that she does not currently have an advance directive and expressed a desire for assistance in creating one due to concerns regarding her current health status. During a concurrent interview and record review on 7/1/2026 at 2:12 p.m. with the Social Service Director (SSD), Resident 2's Advance Directive Acknowledgement dated 3/18/2026 was reviewed. The SSD stated that he was responsible for inquiring about the availability of advance directives from residents and providing additional information as necessary. The SSD explained that upon presenting the advance directive acknowledgment form during admission, once it is signed by the resident, he reviews the document and clarifies any points with the resident or their representative if further information is required. The SSD stated Resident 2 did not have an advance directive, and he did not confirm with Resident 2 whether she still intended to execute one. The SSD stated it was important to assist residents in executing advance directives, particularly since many are not physically able to make such arrangements themselves. The SSD further stated that ensuring that residents' health wishes are (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055856	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2026
NAME OF PROVIDER OR SUPPLIER High Valley Lodge		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented is important, as incomplete forms may result in those wishes not being honored in situations involving illness or death. During an interview on 7/2/2026 at 09:50 a.m. with Director of Nursing (DON), the DON stated that the SSD is responsible for inquiring for availability of advance directives and assisting residents in completing advance directives. The DON stated it is important to inquire about and facilitate advance directives to ensure residents' health care preferences are known if they become unable to make decisions themselves, as well as appointing an individual to assist them with their health-related wishes. The DON further stated that without appropriate assistance in creating advance directives, residents' preferences may not be accurately reflected or communicated through the document. During a review of facility's Policy and Procedure (P&P) titled, Advance Directives, reviewed 2/18/2026, the P&P indicated that prior to or at the time of a resident's admission, the social services director or designee shall provide written information regarding the resident's rights to make decisions about medical care. This includes the right to accept or refuse medical or surgical treatment, as well as the right to establish advance directives. Additionally, the P&P indicated that the social services director or designee will inquire with the resident and/or their family members about the existence of any written advance directives prior to or at the time of admission. The documentation indicating whether the resident has executed an advance directive will be displayed prominently in the medical record. During a review of facility's P&P titled, Resident Rights, reviewed 2/18/2026, the P&P indicated that under planning and implementing care, residents are entitled to be informed of and actively participate in their treatment. These rights include requesting, refusing, or discontinuing treatment; choosing whether or not to participate in experimental research; and formulating an advance directive.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055856	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2026
NAME OF PROVIDER OR SUPPLIER High Valley Lodge		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure reasonable care for the protection of resident's property from loss or theft by failing to have a completed belongings inventory for one of one resident (Resident 45) reviewed under the Personal Property care area. This failure had the potential to result in failure to provide safe keeping of Resident 45's personal belongings. Findings: During a review of Resident 45's Face Sheet (the front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated the facility originally admitted Resident 45 on 12/29/2021 and re-admitted on [DATE] with diagnoses including cerebral infarction (stroke - damage to the tissues in the brain due to a loss of oxygen to the area), chronic obstructive pulmonary disease (COPD - a progressive long term lung disease that makes it hard to breath) and schizophrenia (a mental illness that is characterized by disturbances in thought). The Face sheet indicated Family Member 2 (FM 2) as the responsible party and resident representative for Resident 45. During a review of Resident 45 's Minimum Data Set (MDS - a resident assessment tool) dated 6/9/2026, the MDS indicated Resident 45 had adequate hearing and did not use a hearing aid or other hearing appliance. The MDS indicated Resident 45 usually makes self-understood (difficulty communicating some words or finishing thoughts but is able if prompted or given time) and usually understands (misses some part/intent of message but comprehends most conversations). The MDS indicated Resident 45 was cognitively intact (individual's reasoning, memory, problem-solving, attention, and language capabilities are working as expected for their age). During review of Resident 45's History and Physical (H&P), dated 7/18/2025, the H&P indicated Resident 45 does not have the capacity to understand and make decisions. During an interview on 6/29/2026 at 9:02 a.m. with Resident 45, Resident 45 stated she could not hear well. Resident 45 stated she did not know where the hearing aids were that were brought in by FM 2. Resident 45 stated she was hard of hearing on both her ears and needed to have her ears cleaned. During a review of Resident 45's Inventory (detailed record of patient's personal belongings) dated 12/30/2021, the Inventory indicated that the hearing aid(s) was not included on the list. The Inventory section for signature of resident/responsible party was blank. During an interview on 6/30/2026 at 12:48 p.m. with the Director of Social Services (DSS), the DSS stated that the Inventory is completed on admission. The DSS stated that the DSS or the Social Service Assistant (SSA) would go through resident belongings with the resident or resident and list the items on the Inventory. The DSS stated that the resident or responsible party signs the form on admission to confirm the items on the list. The DSS stated Resident 45's Inventory dated 12/30/2021 should have been signed by FM2 since FM2 is the responsible party for Resident 45. The DSS stated that he may have a different inventory form or an updated version in the file in his office signed by FM2 that has not been filed in Resident 45's medical record. During a subsequent interview and concurrent record review on 6/30/2026 at 1:22 p.m. with the DSS, the Inventory dated 12/30/2021 was reviewed. The Inventory had one signature, under facility representative. The DSS stated he did not locate any other belongings inventory for Resident 45's than the one being reviewed, dated 12/30/2021. The DSS stated that Resident 45's Inventory was invalid since it did not have the responsible party's signature or two facility staff's signatures. The DSS stated that a second staff signature is required when resident or responsible party does not sign the Inventory. The second staff signature serves as a witness validating the items listed in the document. The DSS stated that Resident 45's Inventory is not considered valid since it lacked all (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055856	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2026
NAME OF PROVIDER OR SUPPLIER High Valley Lodge		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	required signatures. The DSS stated it is important to have a complete belongings inventory with the required signatures because without the required signatures, there is no way to confirm that the reportedly missing item had ever been brought into the facility. During an interview of 7/2/2026 at 8:41 a.m. with the Director of Nursing (DON), the DON stated that residents have the right to keep personal belongings. The DON stated all items must be inventoried and documented on the belongings list. The DON stated having the appropriate signatures on the form is important because it serves as both acknowledgement and confirmation of the recorded items. The DON stated that maintaining an updated and complete belongings list supports the safeguarding and tracking of residents' items residents have in the facility. During a review of the facility's policy and procedure (P&P) titled, Resident Personal Belongings and Inventory of Property last reviewed 2/18/2026, the P&P indicated, To ensure the residents' personal belongings and valuables are accurately inventoried, safeguarded, documented, and returned upon transfer or discharge in accordance with resident rights and applicable federal and state regulations. The facility will make reasonable efforts to safeguard residents' personal belongings and maintain accurate inventory of personal property. Upon admission or readmission, nursing staff or designated personnel shall complete a Resident Personal Belongings Inventory with the resident and/or responsible party. Nursing, Admissions, social services, and other designated staff shall ensure inventories are completed and updated as required.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055856	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2026
NAME OF PROVIDER OR SUPPLIER High Valley Lodge		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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 interview and record review, the facility failed to ensure one of 14 sampled residents (Resident 51) had an accurate and complete assessment reflected in the Minimum Data Set (MDS - a resident assessment tool) when the BIMS (Brief Interview for Mental Status-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) screening and Resident Mood Interview (a standardized assessment to screen for potential symptoms of depression) were not completed although the resident was assessed as being sometimes understood (ability is limited to making concrete requests) and sometimes able to understand (responds adequately to simple, direct communication only). This failure resulted in Resident 51 having an inaccurate and incomplete MDS assessment. Findings: ^ During a review of Resident 51's Face Sheet, the Face Sheet indicated the facility admitted the resident on 6/27/2013 with diagnoses including, but not limited to, acute pyelonephritis (a sudden, severe bacterial infection of the kidneys) and vascular (having to do with the blood vessels and circulation) dementia (a progressive state of decline in mental abilities). During a concurrent interview and record review on 7/2/2026 at 12:35 p.m. with the Minimum Data Set Coordinator (MDSC), Resident 51's MDS, dated [DATE], was reviewed. In the MDS section titled, Makes Self Understood, the section indicated the purpose was to assess the resident's ability to express ideas and wants and to consider both verbal and non-verbal expression. The section indicated the options understood, usually understood, sometimes understood, and rarely/never understood. Resident 51's MDS indicated he was sometimes understood (ability is limited to making concrete requests). In the MDS section titled, Ability to Understand Others, the section indicated the purpose was to assess the resident's understanding of verbal content and indicated the options understands, usually understands, sometimes understands, and rarely/never understands. Resident 51's MDS indicated he sometimes understands (responds adequately to simple, direct communication only). In the MDS section titled, Cognitive Patterns, the section indicated the BIMS screening tool should not be completed as the resident is rarely or never understood. In the MDS section titled, Mood, the section indicated the Resident Mood Interview should not be completed as the resident is rarely or never understood. The MDSC stated from her assessment Resident 51 can sometimes be understood and sometimes understand others and stated this information conflicts with the information in the Cognitive Patterns and Mood sections where it was indicated the resident is rarely or never understood. The MDSC stated she believed it would be possible for Resident 51 to complete the BIMS screening and Resident Mood Interview, although the resident might not respond to all of the questions. The MDSC stated the BIMS is important to complete when possible because it allows the facility to monitor changes in the resident's cognitive ability over time and staff can determine whether the resident's cognitive ability is improving or declining. The MDSC stated similarly, the Resident Mood Interview is an important assessment because it helps identify signs and symptoms of depression and monitors changes in the resident's mood. During a review of the facility's policy and procedure (P&P) titled Resident Assessment Instrument, last reviewed 2/18/2026, the P&P indicated a comprehensive assessment of a resident's needs shall be made within 14 days of the resident's admission. The P&P indicated the purpose of the assessment is to describe the resident's capability to perform daily life functions and to identify significant impairments in functional capacity.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055856	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2026
NAME OF PROVIDER OR SUPPLIER High Valley Lodge		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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 observation, interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan (a document outlining a detailed approach to care customized to an individual resident's need) for one of fourteen sampled residents (Resident 45) by failing to address Resident 45's recurring impacted cerumen (a buildup of earwax that causes symptoms like hearing loss, earache, or a feeling of fullness). This failure placed Resident 45 at risk for pain, infection, impaired hearing and communication difficulties. Findings: During a review of Resident 45's Face Sheet, the Face Sheet indicated the facility originally admitted Resident 45 on 12/29/2021, re-admitted on [DATE] with diagnoses that included cerebral infarction (stroke - damage to the tissues in the brain due to a loss of oxygen to the area), chronic obstructive pulmonary disease (COPD - a progressive long term lung disease that makes it hard to breathe) and schizophrenia (a mental illness that is characterized by disturbances in thought). The Face sheet indicated Family Member 2 (FM 2) as the responsible party and resident representative for Resident 45. During a review of Resident's Minimum Data Set (MDS - a resident assessment tool), dated 6/9/2026, the MDS indicated Resident 45 had adequate hearing and did not use a hearing aid or other hearing appliance. The MDS indicated Resident 45 usually makes self-understood (difficulty communicating some words or finishing thoughts but is able if prompted or given time) and usually understands (misses some part/intent of message but comprehends most conversations). The MDS indicated Resident 45 was cognitively intact (individual's reasoning, memory, problem-solving, attention, and language capabilities are working as expected for their age). During review of Resident 45's History and Physical (H&P), dated 7/18/2025, the H&P indicated Resident 6 does not have the capacity to understand and make decisions. During an interview on 6/29/2026 at 9:02 a.m. with Resident 45, Resident 45 stated she could not hear well. Resident 45 stated she was hard of hearing on both ears and needed to have her ears cleaned. During a concurrent interview and record review on 7/1/2026 at 12:12 p.m. with Minimum Data Set Coordinator (MSDC), the Ears, Nose and Throat (ENT - a medical doctor who specializes in medical conditions of the ear, nose, and throat) progress notes dated 12/04/2025 and 6/11/2026 were reviewed. The progress notes dated 12/4/2025 indicated Resident 45 had bilateral (both sides) impacted cerumen. The progress notes indicated under Plan, cerumen removal (clearing out ear wax) and Resident 45 was instructed to avoid using cotton swabs and avoiding placing any objects in her ears and to notify her nurse if she experiences any discomfort in her ears. The progress notes dated 6/11/2026 indicated Resident 45 had bilateral (both sides) impacted cerumen. The progress notes indicated under Plan, cerumen removal (clearing out ear wax) and Resident 45 was instructed to avoid using cotton swabs and avoiding placing any objects in her ears and to notify her nurse if she experiences any discomfort in her ears. The MSDC stated that Resident 45's recurring wax build up required that a care plan be developed and the ENT physician's instructions would be documented under the care plan interventions. The MSDC stated that a care plan had not been developed for Resident 45's recurring wax build up. The MSDC stated a care plan should have been developed after Resident 45's visit with ENT physician on 12/4/2025. The MSDC stated that the MSDC is responsible for reviewing progress notes, laboratory results and other resident records when completing MDS of which at that time, care plans are developed or updated as needed. The (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055856	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2026
NAME OF PROVIDER OR SUPPLIER High Valley Lodge		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MDSC^stated^that developing the care plan^for Resident 45's impacted cerumen^was^missed.^The MDSC^stated^that^having a^care plan^for Resident 45's impacted cerumen was important because it would have informed the care team of^Resident 45's^problem,^the^goals established to address the problem, and the interventions necessary to provide appropriate care.^The MSDC stated that having a care plan^in place may have helped prevent^the recurrence of Resident 45's impacted cerumen.^During an interview of 7/2/2026 at 8:41 a.m. with the DON, the DON stated^that^care plans are developed^from^triggers^identified in the^MDS, new diagnosis,^change of medications,^change^of^condition, or^from^specialists^(physicians^with^medical specialty expertise)^orders^or instructions.^The DON^stated^that a^care plan^identifies^the problem, goals, interventions^specific^for^the^resident.^The DON^stated^that a care plan is necessary for potential or actual problem^identified^because without it,^there is a^potential for the problem to be unaddressed^or necessary care to be delayed.^The DON^stated^that the MDSC^and charge^nurses^are responsible for^developing and updating care plans.^During a review of facility's P&P titled, Comprehensive Resident Centered Care Plans,^reviewed 2/18/2026, the P&P indicated^that the facility is committed to promoting cohesive interdisciplinary care for residents by employing a comprehensive^plan based on assessment, planning, treatment, services, and interventions. This approach^facilitates^effective management and documentation of resident care from admission through discharge. The primary^objective^is to deliver individualized, goal-oriented, reasonable, and measurable care tailored to each resident's needs. Appropriate interventions are implemented to support interdisciplinary communication and ensure continuity of care. Furthermore, the facility^is required to^develop and execute a person-centered care plan for every resident, aligning with established resident rights and incorporating measurable^objectives^and timelines to address medical, nursing, mental, and psychosocial needs^identified^in the comprehensive assessment.^		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055856	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2026
NAME OF PROVIDER OR SUPPLIER High Valley Lodge		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation, interview, and record review, the facility failed to ensure medication was properly stored when one of one inspected medication carts (Medication Cart South) had unlabeled, unpackaged tablets in the bottom of two cart drawers. This failure resulted in the improper storage of medication. Findings: During a concurrent observation and interview on 6/30/2025 at 1:32 p.m., with the Minimum Data Set Coordinator (MDSC), at Medication Cart South, observed a whole white round tablet, two halves of a white round tablet, and debris at the bottom of a medication cart drawer. There were two white round tablets, two pieces of a white round tablet, and debris at the bottom of another medication cart drawer. The tablets were not labeled or in packaging. The MDSC stated the tablets should not be like that as they don't know who those belonged to, who would be missing those medications, and they don't know what the medications are. During an interview on 7/2/2026 at 2:52 p.m., with the Director of Nursing (DON), the DON stated loose medications are a medication storage issue because they don't know what the medications are or which residents they belong to. During a review of the facility's policy and procedure (P&P) titled, Storage of Medication, last reviewed 2/18/2026, the P&P indicated medications are stored properly following manufacturer's recommendations or those of the supplier to maintain their integrity and to support safe administration. The P&P indicated outdated, contaminated, or deteriorated medications are immediately removed from stock and disposed of according to procedures for medication disposal and reordered from the pharmacy if a current order exists.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055856	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2026
NAME OF PROVIDER OR SUPPLIER High Valley Lodge		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review, the facility failed to ensure the resident's medical records for advance directives (written statement of a person's wishes regarding medical treatment made to ensure those wishes are carried out should the person be unable to communicate them to a doctor) was clarified and completed accurately for one of five sampled residents (Resident 2). This failure had the potential to result in confusion in the care and services for Resident 2 and placed the resident at risk of receiving unwanted treatment and not receiving appropriate care based on her wishes. Findings: During a review of Resident 2's Face Sheet, the Face Sheet indicated that the facility initially admitted Resident 2 to the facility on 3/6/2026, with diagnoses including type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), chronic systolic heart failure (a condition in which the heart does not pump blood as well as it should), depression (a mood disorder that causes persistent feeling of sadness and loss of interest), and generalized anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety or fear that are strong enough to interfere with one's daily activities). During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool) dated 3/19/2026, the MDS indicated that Resident 2's cognition (mental action or process of acquiring knowledge and understanding) was intact. The MDS indicated Resident 2 was ranging from set-up assistance (helper assists only prior to or following the activity) to maximal assistance (helper does more than half the effort) for physical assistance from staff for activities of daily living (ADLs - eating, toileting, hygiene, shower/bathing). During a review of Resident 2's Initial History and Physical dated 3/7/2026, the H&P indicated that Resident 2 had the capacity to understand and make decisions. During a review of Resident 2's Advance Directive Acknowledgement dated 3/18/2026, the advance directive acknowledgment indicated that Resident 2 marked, I have executed an Advance Directive and I wish to execute an Advance Directive. The advance directive acknowledgement indicated that facility representative did not have a signature. During a review of Resident 2's Physician Orders for Life-Sustaining Treatment (POLST - a portable medical order form that records patients' treatment wishes so that emergency personnel know what treatments the patient wants in the event of a medical emergency) dated 3/27/2025, the POLST indicated Resident 2's advance directive was not available. During a concurrent interview and record review on 7/1/2026 at 2:12 p.m., with the Social Service Director (SSD), reviewed Resident 2's advance directive acknowledgement dated 3/18/2026. The SSD indicated that he was responsible for inquiring about the availability of advance directives from residents and providing additional information as necessary. The SSD explained that upon presenting the advance directive acknowledgment form during admission, once it is signed by the resident, he reviews the document and clarifies any points with the resident or their representative if further information is required. The SSD stated that Resident 2's advance directive acknowledgment form contained an error and was contradictory; it indicated both that Resident 2 had an advance directive and wished to execute one. The SSD stated that a facility representative should also sign the form. The SSD acknowledged this oversight and the failure to resolve the conflicting information. Additionally, the SSD emphasized that ensuring that residents' health wishes are documented is crucial, as incomplete forms may result in those wishes not being honored in situations involving illness or death. During an interview on 7/2/2026 at 9:50 a.m., with the Director of Nursing (DON), the DON stated that the SSD is responsible for both inquiring about the availability of advance directive and assisting residents in completing advance directives. The DON emphasized her expectation that (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055856	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2026
NAME OF PROVIDER OR SUPPLIER High Valley Lodge		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff should document accurately, completely, and timely. Additionally, the DON stated the importance of ensuring documentation provides a comprehensive overview of the resident, including their plan of care. During a review of facility's Policy and Procedure (P&P) titled, Advance Directives, reviewed 2/18/2026, the P&P indicated that prior to or at the time of a resident's admission, the social services director or designee shall provide written information regarding the resident's rights to make decisions about medical care. This includes the right to accept or refuse medical or surgical treatment, as well as the right to establish advance directives. Additionally, the P&P indicated that the social services director or designee will inquire with the resident and/or their family members about the existence of any written advance directives prior to or at the time of admission. The documentation indicating whether the resident has executed an advance directive will be displayed prominently in the medical record. During a review of facility's P&P titled, Health Information Record Manual, reviewed 2/18/2026, the P&P indicated that documentation within the legal health record must adhere to the following guidelines: all entries must include the appropriate date and time and be signed. Manual records are required to be legible, and any use of initials must correspond to a valid signature in the record that can be easily traced to the relevant document. Documentation should be recorded promptly as events or observations occur and must be complete, concise, descriptive, factual, and accurately reflect the services provided to or for the resident.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055856	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2026
NAME OF PROVIDER OR SUPPLIER High Valley Lodge		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on interview and record review, the facility failed to offer the updated 2025/2026 influenza (flu, a contagious respiratory illness caused by influenza viruses that infect the nose, throat, and lungs) vaccine (medications used to prevent diseases usually given by injection or by mouth) at the start of the respiratory illness season (typically from October through April in the U.S., peaking between December and February, characterized by increased circulation of respiratory illnesses including the flu) when the vaccine became available for one of five sampled residents (Resident 1). This failure had the potential to increase Resident 1's risk of acquiring the flu virus and experiencing complications from the flu virus. Findings: ~ During a review of Resident 1's Face Sheet, the Face Sheet indicated the facility admitted the resident on 3/26/2025 with diagnoses including, but not limited to, chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing) and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 1's History and Physical Examination dated 2/16/2026, the History and Physical Examination indicated Resident 1 had fluctuating capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 4/9/2026, the MDS indicated Resident 1 was cognitively intact (able to think, learn, and remember clearly). The MDS indicated Resident 1 was dependent (helper does all the effort) on staff for toileting, showering, lower body dressing, and putting on and taking off footwear. The MDS indicated Resident 1 required substantial assistance (helper does more than half of the effort) with upper body dressing and required partial assistance (helper does less than half of the effort) with oral hygiene. During a concurrent interview and record review on 7/1/2026 at 1:34 p.m., with the Infection Preventionist (IP), reviewed Resident 1's Preventative Health Care Report, dated 1/1/2025 to 7/2/2026. The Preventative Health Care Report indicated Resident 1 refused the flu vaccine on 3/27/2025. Resident 1's Preventative Health Care Report did not indicate any other dates the resident was offered the flu vaccine. The IP stated he usually starts offering the flu vaccine in September. The IP stated since Resident 1 was admitted in March and adamantly refused the flu vaccine when she was admitted, he did not offer it for the next flu season as he understood Resident 1 did not want any further vaccines. The IP stated there was no documentation or care plan addressing Resident 1's refusal of all further vaccinations. During an interview on 7/2/2025 at 1:12 p.m., with the IP, the IP stated flu vaccines should be offered to residents every year around September when the vaccine becomes available. The IP stated he should have offered Resident 1 the flu vaccine in September 2025 when the vaccine became available for that flu season. The IP stated if the flu vaccine is not offered the resident has the potential to be at risk for more severe complications from the flu like fever, respiratory problems, body aches, and a worse flu illness. During a review of the facility's policy and procedure (P&P) titled, Influenza Immunization - Flu Vaccine, last reviewed 2/18/2026, the P&P indicated flu season is defined as October 1 to March 31. The P&P indicated the immunization process will begin when the flu vaccine becomes available. The P&P indicated the record of the immunization process will include the date the vaccine was administered or refused and why.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055856	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2026
NAME OF PROVIDER OR SUPPLIER High Valley Lodge		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview and record review, the facility failed to offer the updated 2025 Coronavirus disease (COVID-19 a highly contagious respiratory illness) vaccine (medications used to prevent diseases usually given by injection or by mouth) when the vaccine became available for one of five sampled residents (Resident 1). This failure had the potential to increase Resident 1's risk of getting COVID-19. Findings: ^ During a review of Resident 1's Face Sheet, the Face Sheet indicated the facility admitted the resident on 3/26/2025 with diagnoses including, but not limited to, chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing) and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 1's History and Physical Examination dated 2/16/2026, the History and Physical Examination indicated Resident 1 had fluctuating capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 4/9/2026, the MDS indicated Resident 1 was cognitively intact (able to think, learn, and remember clearly). The MDS indicated Resident 1 was dependent (helper does all the effort) on staff for toileting, showering, lower body dressing, and putting on and taking off footwear. The MDS indicated Resident 1 required substantial assistance (helper does more than half of the effort) with upper body dressing and required partial assistance (helper does less than half of the effort) with oral hygiene. During a concurrent interview and record review on 7/1/2026 at 1:34 p.m., with the Infection Preventionist (IP), reviewed Resident 1's Preventative Health Care Report, dated 1/1/2025 to 7/2/2026. The Preventative Health Care Report indicated Resident 1 refused the COVID-19 vaccine on 3/27/2025. Resident 1's Preventative Health Care Report did not indicate any other dates the resident was offered the COVID-19 vaccine. The IP stated since Resident 1 was offered COVID-19 vaccination in March 2025 and refused it, the IP did not offer the updated vaccine when it became available in fall 2025 as he understood Resident 1 did not want any further vaccines. The IP stated there was no documentation or care plan addressing Resident 1's refusal of all further vaccinations. During an interview on 7/2/2025 at 1:12 p.m., with the IP, the IP stated residents should be offered updated COVID-19 vaccinations as they become available. The IP stated the last COVID-19 vaccination became available around the same time the flu vaccine was available in 2025, around September. The IP stated he did not offer Resident 1 the updated 2025 COVID-19 vaccination once it did become available. The IP stated if the updated COVID-19 vaccination is not offered the resident has the potential to be at risk for more severe complications from COVID-19 like severe respiratory problems. During a review of the facility's policy and procedure (P&P) titled, Covid-19 Prevention, last reviewed 2/18/2026, the P&P indicated as soon as a vaccine is available, the facility will offer vaccination to each resident and staff member. The P&P indicated the facility will provide the opportunity for each person to accept or refuse the vaccine, and to change their decision. During a review of the facility's COVID-19 Mitigation Plan, last updated 5/1/2025, the plan indicated the facility will offer, track, and report COVID-19 vaccination doses. The plan indicated the facility must educate and offer recommended vaccine doses as soon as recommendations are released by the Centers for Disease Control and Prevention (CDC, the national public health agency of the United States) and doses are made available to the facility, for both residents and staff.		