STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056363	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grand Valley Health Care Center	13524 Sherman Way Van Nuys, CA 91405

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 - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 42275 Based on observation, interview, and record review, the facility failed to ensure a resident received treatment and care in accordance with professional standards of practice for one of four sampled resident (Resident 2) by failing to follow-up with the physician to obtain an order to continue monitoring Resident 2's surgical wound with non-removable dressing. This deficient practice had the potential for Resident 2 to have a wound infection. Findings: During a review of Resident 2 ' s Admission Record, the Admission Record indicated the facility admitted the resident on 11/22/2024 with diagnoses including left hip fracture (broken bone) subsequent (following) encounter for orthopedic (relating to the orthopedics, the medical specialty that treats the bones, muscles, joints, and nerves) aftercare and dementia (a progressive state of decline in mental abilities). During a review of Resident 2 ' s Minimum Data Set (MDS - a resident assessment tool) dated 11/28/2024, the MDS indicated the resident ' s cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was severely impaired. The MDS further indicated that the resident was dependent on staff with lower body dressing and needed maximum assistance with bed mobility (movement), and transfer. During a review of Resident 2 ' s physician order dated 11/23/2024, indicated an order to monitor Resident 2's left hip surgical wound with non-removable dressing for signs and symptoms of infection, every day shift for 14 days, dressing will be removed by the surgeon. During a review of Resident 2 ' s physician orders summary report, an order dated 12/11/2024 indicated Resident 2 ' s orthopedic follow up appointment was scheduled on 12/13/2024 at 8:30 a.m. (continued on next page)

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

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 12/12/2024 at 12:48 p.m., with Treatment Nurse 1 (TN 1), TN 1 reviewed Resident 2 ' s physician order to monitor left hip surgical wound for the signs and symptoms of infection dated 11/23/2024 and Treatment Administration Record (TAR - a daily documentation record used by a licensed nurse to document treatments given to a resident) for 12/2024. TN 1 stated that the order was to monitor Resident 2 ' s surgical wound for 14 days from 11/23/2024 to 12/7/2024. TN 1 stated after 12/7/2024, the licensed nurses were no longer documenting monitoring of Resident 2 ' s surgical wound in the TAR. TN 1 stated that he monitored Resident 2 ' s surgical wound but did not document. During a concurrent observation and interview on 12/12/24 at 1 p.m., in Resident 2 ' s room, TN 1 observed that Resident 2 ' s left hip surgical wound was partially covered with a non-removable dressing and two spots with some staples (small, metal clips called surgical staples to close a cut on the skins). TN 1 stated that did not see the staples yesterday, 12/11/2024, because the surgical wound was completely covered with the non-removable dressing. During a concurrent interview and record review on 12/12/24 at 1:28 p.m., with the Assistant Director of Nursing (ADON), the ADON reviewed Resident 2 ' s physician order to monitor surgical wound for the signs and symptoms of infection dated 11/23/2024 and the TAR for 12/2024. The ADON stated that the order to monitor surgical wound was for 14 days from 11/23/2024 to 12/7/2024, but a licensed nurse should have reevaluated Resident 2 ' s surgical wound on the 14thday of monitoring and notify the physician of the wound assessment so the physician is aware of the need to continue monitoring the resident ' s wound. The ADON stated if the licensed nurses are not documenting the monitoring of the resident ' s wound, then it is considered as not having been done. The ADON stated that Resident 2 ' s orthopedic follow up appointment was scheduled on 12/13/2024, so Resident 2 ' s surgical wound needed to be monitored by the licensed nurses until the facility staff receive a new order from the orthopedics. During a review of the facility policy and procedure titled, Wound Care, last reviewed on 8/15/2024, indicated, It is the policy of the facility to provide guidelines for the care of wounds to promote healng Documentation: The following information should be documented in the resident ' s clinical records Right and time under care was given Any change in the resident ' s condition Report other information in accordance with facility policy and professional standards of practice.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42275 Based on interview and record review, the facility failed to ensure administration of a physician ordered eye drop was accurately documented in the Medication Administration Record (MAR- a daily documentation record used by a licensed nurse to document medications given to a resident) for one of four sampled residents (Resident 3). This deficient practice had the potential to result in confusion in the delivery of care and placed the resident at risk for not receiving the medication as ordered by the physician. Findings: During a review of Resident 3 ' s Admission Record, the Admission Record indicated the facility admitted the resident on 10/29/2024 with diagnoses that included glaucoma (eye diseases that can cause vision loss and blindness by damaging a nerve in the back of eyes). During a review of Resident 3 ' s Minimum Data Set (MDS - a resident assessment tool) dated 11/4/2024, the MDS indicated the resident ' s cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was intact. The MDS further indicated that the resident needed supervision or touching assistance with oral hygiene and personal hygiene, needed moderate assistance with bed mobility (movement), and needed maximum assistance with transfer. During a review of Resident 3 ' s physician order summary report, the report indicated an order to instill latanoprost (used to treat certain kinds of glaucoma) ophthalmic (relating to the eyes) solution 0.005 %, or Latanoprost, one drop in both eyes at bedtime for glaucoma. During an interview on 12/12/2024 at 9:20 a.m., with Resident 3 in the resident ' s room, Resident 3 stated that she did not receive her (Resident 3) eye drops for glaucoma in the evening on the day of her admission. During a review of 3 ' s Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications given to a resident) for 10/2024, the MAR indicated that Licensed Vocational Nurse 3 (LVN 3) administered Latanoprost to Resident 3 ' s eyes on 10/29/2024 at 9 p.m. During a concurrent interview and record review on 12/12/24 at 11:20 a.m., with the Assistant Director of Nursing (ADON), the ADON reviewed Resident 3 ' s medication delivery receipt dated 10/30/2024 timed 2:46 a.m. and stated that Resident 3's MAR indicated that LVN 3 documented Resident 3 ' s Latanoprost was administered on 10/29/2024 at 9 p.m., but Resident 3 ' s Latanoprost was delivered to the facility on [DATE] at 2:43 a.m. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 12/12/24 at 3:06 p.m., LVN 3 reviewed Resident 3 ' s MAR for 10/2024 and stated Resident 3 ' s Latanoprost was not delivered on the day of admission, 10/29/2024 and she (LVN 3) incorrectly documented in the MAR that Latanoprost was administered. LVN 3 stated it is important to document medication administration accurately in the MAR to ensure continuity of services to the resident. LVN 3 further stated incorrect documentation of medication administration could result in negative outcomes. During an interview on 12/12/24 at 4:08 p.m., with the Director of Nursing (DON), the DON stated, if any medications were not available especially on the day of admission, the licensed nurses should have notified the physician the medication was not available and document accurately in the MAR to prevent negative outcomes for the resident During a review of the facility policy and procedure titled, Medication Administration - General Guidelines, last reviewed on 8/15/2024, indicated, medications are administered in accordance with written orders of the attending physician .the individual who administers the medication dose records the administration on each resident ' s MAR directly after the medication is given .if a dose of regularly medication is withheld, refused, or given at other than the scheduled time, the space provided on the front of the MAR for that dosage administration is initialed and circled, an explanatory note is entered on the reverse side of the record provided for PRN documentation.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42275 Based on observation, interview, and record review, the facility failed to implement infection control practices by failing to: 1. Ensure Licensed Vocational Nurse 2 (LVN 2) perform hand hygiene (HH - the practice of cleaning hands to prevent the spread of germs and infections) after checking a resident ' s blood pressure with bare hands for one of four sampled residents (Resident 3). 2. Ensure Treatment Nurse 1 (TN 1) perform hand hygiene between glove changes while providing wound treatment to one of four sampled residents (Resident 4). These deficient practices had the potential to result in the spread of germs placing residents, staff, and visitors at risk for infection. Findings: 1. During a review of Resident 3 ' s Admission Record, the Admission Record indicated the facility admitted the resident on 10/29/2024 with diagnoses including glaucoma (eye diseases that can cause vision loss and blindness by damaging a nerve in the back of your eye). During a review of Resident 3 ' s Minimum Data Set (MDS - a resident assessment tool) dated 11/4/2024, the MDS indicated the resident ' s cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was intact. The MDS further indicated that the resident needed supervision or touching assistance with oral hygiene and personal hygiene, needed moderate assistance with bed mobility (movement), and needed maximum assistance with transfer. During a medication pass observation on 12/12/2024, at 8:04 a.m., with LVN 2, observed LVN 2 checking Resident 3 ' s blood pressure with bare hands then returned to the medication cart without performing HH. When LVN 2 was asked what LVN 2 should have done before touching the medication cart, LVN 2 stated she forgot to wear gloves before taking Resident 3 ' s blood pressure and perform HH after taking Resident 3 ' s blood pressure. LVN 2 stated she should have performed HH to reduce the risk of cross contamination (occurs when one object becomes contaminated by either direct or indirect contact with another object which is already contaminated). 2. During a review of Resident 4 ' s Admission Record, the Admission Record indicated the facility originally admitted the resident on 12/8/2020 and readmitted on [DATE] with diagnoses that included lymphedema (a condition in which lymph builds up in tissues and causes swelling). During a review of Resident 4 ' s MDS dated [DATE], the MDS indicated the resident ' s cognitive skills for daily decision making was intact. The MDS further indicated that the resident needed maximum assistance with upper/lower body dressing and transfer. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation of Resident 4 ' s wound treatment, on 12/12/2024, at 9:38 a.m., with TN 1, observed that TN 1 performed HH and wore gloves before providing Resident 4 ' s wound treatments. TN 1 removed the resident ' s old dressing on the right foot then changed gloves without performing HH, proceeded to clean the wound with normal saline (NS - a solution of water and salt with the concentration of 0.9% sodium chloride) from the inside of the wound to the outside using one stroke each time, applied betadine followed by Santyl (used to remove damaged tissue from chronic skin ulcers), and covered the wound with a new dressing. TN 1 did not perform HH between glove changes. After completing the treatment to the resident ' s right foot, TN 1 changed gloves without performing hand hygiene and proceeded to apply Baza cream (a moisture barrier cream) to Resident 4 ' s right thigh posterior (back) area. After TN 1 completed the wound treatments for Resident 4, TN 1 took off the gloves and washed his hands in the bathroom inside the resident ' s room and documented the treatments provided to the resident. During a further interview on 12/12/2024 at 9:50 a.m., with TN 1, TN 1 was asked about performing hand hygiene in between glove changes. TN 1 stated that forgot to perform HH between glove changes during wound treatments to Resident 4. TN 1 stated it is important to perform hand hygiene between glove changes to prevent cross contamination. During an interview on 12/12/2024 at 10:01 a.m., with the Infection Control Preventionist (ICP), the ICP stated that the licensed nurse should perform HH before and after wearing gloves, LVN 2 should perform HH after checking the resident ' s blood pressure and before preparing medications. The ICP further stated that the TNs should perform HH before providing wound treatments, between glove changes during wound treatments, and at the end of the wound treatment services to prevent cross contaminations. During a review of the facility policy and procedure (P&P) titled, Infection Control Program System, last reviewed on 8/15/2024, the P&P indicated, the facility has an established infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. During a review of the facility P&P titled, Hand Hygiene, last reviewed on 8/15/2024, indicated, It is the policy of the facility that all staff members perform hand hygiene before and after direct resident care and after contact with the potentially contaminated substances to prevent, to the extent possible, the spread of infection Hand hygiene will be performed by staff as follows Before touching a resident; if gloves will be worn, before gloving; After touching a resident Before and after touching any kinds of wound