

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 08/08/2025
NAME OF PROVIDER OR SUPPLIER Grand Valley Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (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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<p>F 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1) was actively involved in their discharge planning and had a safe discharge to a lower level of care. This deficient practice resulted in Resident 1 having to be admitted to the general acute care hospital (GACH) within 24 hours of discharge to a lower level of care and had the potential for decreased quality of care, decreased quality of life, and continuity of care. During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 6/13/2025 with diagnosis including chronic venous hypertension with ulcer (long-lasting skin sore on the leg, caused by poor blood flow in the veins) of left lower extremity and methicillin resistant staphylococcus aureus infection (a bacterial infection caused by a type of bacteria that has become resistant to many of the antibiotics used to treat ordinary infections). During a review of Resident 1's History & Physical (H&P) dated 6/14/2025, the H&P indicated the resident does have capacity to make decisions. During a review of Resident 1's Social Work Progress Note dated 7/24/2025, the Social Work Progress Note indicated Resident 1 met with referral agency. Referral agency spoke to Resident 1 and informed Resident 1 that the referral agency will find the right placement for Resident 1. Resident 1 agreed. During a review of Resident 1's Social Work Progress Note dated 7/31/2025, the Social Work Progress Note indicated that the Social Services Director (SSD) received a call from the referral agency and stated that the referral agency has a facility for Resident 1 to be placed and provided the SSD with the address of the board and care (licensed residential settings that provide housing, meals, and personal care assistance to seniors who need help with daily living activities but don't require 24-hour skilled nursing care) and contact information. The SSD placed a call to the accepting board and care and stated that the board and care has accepted Resident 1 and has a bed available for Resident 1. The SSD requested the board and care to come and evaluate Resident 1, however the board and care stated that the board and care has all the information and was not necessary. The document continued to indicate that the SSD met with Resident 1 and Resident 1 was made aware the board and care has an available bed. During a review of Resident 1's Social Work Progress Note dated 7/31/2025, the Social Work Progress Note indicated Resident 1 agreed to be discharged on 8/2/2025. During a review of Resident 1's physician order dated 8/1/2025 timed at 3:56 p.m., the physician order indicated discharge resident to resident to board and care with home health. During a review of Resident 1's Nursing Progress Note dated 8/2/2025, the Nursing Progress Note indicated that Resident 1 left (discharged) stable. During a review of Resident 1's Social Work Progress Note dated 8/4/2025, the Social Work Progress Note indicated that the SSD was informed by admissions that Resident 1 was sent to the hospital from the board and care. During a review of Resident 1's GACH Physician Progress Notes dated 8/5/2025, the GACH Physician Progress Notes indicated Resident 1 was admitted on [DATE] and was diagnosed with a urinary tract infection (UTI- an infection in the bladder/urinary tract). Resident 1's care plan indicated intravenous (IV- fluids given directly into the blood stream) ceftriaxone (antibiotic used to treat bacterial infections in many different parts of the body) 1,000 milligrams (mg- unit of measurement) daily, and infectious disease follow-up. During an interview on 8/7/2025 at 4:22 p.m., with the SSD, the SSD stated that the discharge process starts on admission. The SSD stated that the SSD will discuss discharge planning with residents and/or residents' representatives in regards to discharge planning and the SSD provides information and choices on various types of lower level care facilities if requested. The SSD stated that Resident 1's discharge plan was to go to a lower level of care such as an assisted living facility or a board and care. The SSD stated that she was able to find a referral agency to assist Resident 1 in finding placement. The SSD stated that the referral agency was able to find placement for Resident 1. The SSD continued to state that the SSD provided the board and care address to Resident 1. When asked if Resident 1 was given a choice in what board and care Resident 1 would be discharged to, the SSD stated that Resident 1 was not given a choice. When asked if Resident 1 was offered to see and tour the prospective board and care that Resident 1 would be discharged to, the SSD stated that the SSD did not ask Resident 1 if he (Resident 1) wanted to see and/or tour the prospective board and care. The SSD further stated that the SSD spoke to the referral agency that found the board and care for Resident 1 and received the address. The SSD stated that the SSD then provided the address of the board and care to Resident 1 and no additional orientation was provided to Resident 1 prior to Resident 1's discharge. When asked if the SSD would move into a facility without seeing the location first, the SSD stated that she would not move to a place</p>		

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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p>(continued on next page)</p>

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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents' Notice of Proposed Transfer and Discharge were provided to the resident and/or resident representative at least 30 days prior to discharge or as soon as practicable for three of three sampled residents (Resident 1, Resident 2, and Resident 3). This deficient practice placed the residents at increased risk of an inappropriate discharge and denied the residents the right to file an appeal to the appropriate agency within 10 days of being notified of a proposed transfer and discharge. a. During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 6/13/2025 with diagnosis including chronic venous hypertension with ulcer (long-lasting skin sore on the leg, caused by poor blood flow in the veins) of left lower extremity and methicillin resistant staphylococcus aureus infection (a bacterial infection caused by a type of bacteria that has become resistant to many of the antibiotics used to treat ordinary infections). During a review of Resident 1's History & Physical (H&P) dated 6/14/2025, the H&P indicated the resident does have capacity to make decisions. During a review of Resident 1's Social Work Progress Note dated 7/31/2025, the Social Work Progress Note indicated Resident agreed to be discharged on 8/2/2025. During a review of Resident 1's physician order dated 8/1/2025 timed at 3:56 p.m., the physician order indicated discharge resident to resident to board and care (licensed residential settings that provide housing, meals, and personal care assistance to seniors who need help with daily living activities but don't require 24-hour skilled nursing care) with home health. During a review of Resident 1's document titled, Notice of Transfer/Discharge, dated 8/2/2025, the Notice of Transfer/Discharge document indicated the notification with given to Resident 1 on 8/2/2025. During a concurrent interview and record review on 8/8/2025 at 10:00 a.m., with the Assistant Director of Nursing (ADON), reviewed Resident 1's Social Work Progress Note dated 7/31/2025. The ADON stated that once the facility is aware of a resident's discharge, licensed nurses and social services should give the resident and/or resident responsible party the notice of transfer and discharge. The ADON stated that Resident 1 should have been given the Notice of Transfer/discharge on [DATE] when social services was aware of the upcoming discharge to the board and care. The ADON stated that it is important to give residents' and/or residents' representative the Notice of Transfer/Discharge to inform the resident and/or resident representative that the resident will be transferred or discharged. The DON stated it will give the residents and/or residents' representative the opportunity to appeal if they do not agree with the discharge. The ADON further stated that Resident 1 was discharged to the board and care on 8/2/2025. b. During a review of Resident 2's admission Record, the admission Record indicated the facility readmitted Resident 2 on 7/13/2025 with diagnosis including urinary tract infection (an infection in the bladder/urinary tract), cellulitis (a skin infection that causes swelling and redness) of the right lower limb, and cellulitis of the left lower limb. During a review of Resident 2's H&P dated 7/15/2025, the H&P indicated the resident does have capacity to make decisions. During a review of Resident 2's care plan (a document that summarizes a resident's needs, goals, and care/treatment) for discharge planning dated 7/14/2025, the care plan indicated Resident 2 plans to return to Assisted Living Facility (housing facility for one who chooses not to live independently) after rehabilitation services have been completed and her health improves. During a review of Resident 2's physician order dated 8/1/2025 timed at 4:17 p.m., the physician order indicated to discharge resident back to ALF on 8/2/2025. During a review of Resident 2's document titled, Notice of Proposed Transfer /Discharge, dated 8/2/2025, the Notice of Transfer/Discharge document indicated the notification was given to Resident 2 on 8/2/2025. During a concurrent interview and record review on 8/8/2025 at 11:06 a.m., with the Case Manager (CM), reviewed Resident 2's Notice of Transfer/discharge date d 8/2/2025 and Resident 2's Notice of Medicare Non-Coverage (NOMNC- written notice designed to inform Medicare members that their covered care is ending) dated 7/30/2025. The CM stated that Resident 2 was admitted for a short-term stay for rehabilitation. The CM stated that the NOMNC is given to the resident and/or resident's representative 72 hours before the last insurance cover date, in which the resident will be discharged from insurance coverage. The CM stated that Resident 2's Notice of Transfer/Discharge was given to Resident 2 on 8/2/2025, the day of Resident 2's discharge. The CM continued to state that the Notice of Transfer/Discharge document is given on the day of discharge and is provided to the residents and/or resident's representative on the day of discharge along with other discharge documents. The CM stated that the Notice of Transfer/Discharge should have been given to Resident 2 on 7/30/2025 when the NOMNC was given c. During a review of</p>		