

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 08/22/2025
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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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<p>F 0550</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 treated with dignity and respect by not honoring Resident 1's request that Certified Nursing Assistant (CNA) 1, whom Resident 1 reported as being rough during care, not provide care to Resident 1 upon readmission to the facility. During a review of Resident 1's admission record, the admission Record indicated the facility admitted Resident 1 on 7/8/2025 and readmitted on [DATE] with diagnoses including fracture of the left femur (break of the long bone in the leg), osteoporosis (weak and brittle bones due to lack of calcium and vitamin D), rheumatoid arthritis (a chronic progressive disease-causing inflammation in the joints and resulting in painful deformity and immobility), morbid obesity (severely overweight), and generalized anxiety disorder (a mental health condition characterized by excessive, uncontrollable worry about everyday events). During a review of Resident 1's History and Physical (H&P) dated 7/22/2025, the H&P indicated Resident 1 has decision-making capacity. During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool) dated 7/27/2025, the MDS indicated Resident 1's cognition (ability to think and make decisions) was intact. The MDS further indicated that Resident 1 required set up assist with eating and personal hygiene and dependent on staff for toileting, showering, and lower and upper body dressing. During an interview on 8/22/2025 at 12:40 p.m. with Resident 1, Resident 1 stated that upon readmission to the facility, Resident 1 spoke with the facility case manager (CM) and requested that CNA 1 not to be in her presence or provide care for Resident 1. Resident 1 stated that the CM acknowledged the request and stated that CNA 1 would not be providing care for Resident 1 or be in her presence. Resident 1 stated that a few days following readmission to the facility CNA 1 was assigned to provide care to Resident 1's roommate and that CNA 1 did come into Resident 1's room and she felt uncomfortable with CNA 1 being in the room. Resident 1 stated that Resident 1 did inform the staff at the facility and CNA 1 was removed from that assignment. During an interview on 8/22/2025 at 2:40 p.m. with CNA 1, CNA 1 stated that on 7/25/2025 CNA 1 worked overtime on the 3 p.m. to 11p.m. shift and CNA 1 was assigned to Resident 1's room. CNA 1 stated that CNA 1 informed the assistant director of staff development (ADSD) that CNA 1 was not allowed to work with Resident 1. The ADSD then informed CNA 1, that CNA 1 will be assigned to the roommate of Resident 1. CNA 1 stated that she did enter Resident 1's room and informed Resident 1 that CNA 1 would be taking care of Resident 1's roommate. CNA 1 stated that Resident 1 did not say anything. CNA 1 further stated that during the shift on 7/25/2025 the call light (a communication device that allows residents to alert caregivers when they need assistance) in Resident 1's room did turn on and CNA 1 went to answer the call light and the call light was for Resident 1 who was requesting ice water. CNA 1 stated that she assisted Resident 1 by providing ice water. During an interview on 8/22/2025 at 3:15 p.m. with ADSD, ADSD stated that on 7/25/2025 ADSD made the assignment sheet for the 3 p.m. to 11 p.m. and originally assigned CNA 1 to Resident 1 but was informed that CNA 1 was not allowed to work with Resident 1. ADSD stated that ADSD changed the assignment and removed CNA 1 from Resident 1's room around 3 p.m. During an interview on 8/22/2025 at 3:25 p.m. with the CM, the CM stated that prior to Resident 1's readmission to the facility on 7/21/2025, the CM was informed that Resident 1 did not want CNA 1 to provide care for Resident 1 or be around CNA 1. During an interview on 8/22/2025 at 4:20 p.m. with the Director of Nursing (DON), the DON stated that Resident 1 had requested CNA 1 not provide care for Resident 1 upon readmission to the facility. The DON confirmed that CNA 1 entered Resident 1's room and spoke to Resident 1. The DON stated that CNA 1 should not have spoken to Resident 1 or entered the room or had any contact with Resident 1. The DON stated that the presence of CNA 1 in Resident 1's room has the potential to cause increased anxiety, fear and feelings of discomfort. During a review of the facility policy and procedure (P&P) titled Resident's Right to Dignity and Privacy dated 8/15/2024, indicated it is the policy of the facility that each resident shall be cared for in a manner that promotes dignity, respect and individuality and provides for resident privacy. The facility will protect and promote the rights of the resident. Resident shall be treated with dignity and respect at all times. to be encouraged and assisted to exercise rights as a resident and as a citizen, and voice grievances without interference, coercion, fear of discrimination or reprisal and to be supported by the facility in the exercise of his or her rights and to recommend changes in policies and services to facility staff and/or outside representatives of the resident's choice and to have the facility respond to those grievances</p>		