STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056363	A. Building B. Wing	04/30/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility's licensed nurses failed to accurately assess and complete fall risk evaluations for one of four sampled residents (Resident 1).These deficient practices had the potential to place the residents at increased risk for injury related to falls.During a review of Resident 1's admission Record, the admission Record indicated that the facility originally admitted Resident 1 on 3/18/2026 and readmitted on [DATE] with diagnoses that included metabolic encephalopathy (ME - a disorder that affects brain function), dehydration (when the body uses or loses more fluid than it takes in), diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing), anemia (a condition where the body does not have enough healthy red blood cells), dementia (a progressive state of decline in mental abilities), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (paralysis or weakness on one side of the body) following cerebral infarction (stroke, loss of blood flow to a part of the brain resulting in damage to brain tissue), chronic kidney disease (a long-term condition where the kidneys are damaged and cannot effectively filter waste and extra fluid from the blood), and repeated falls.During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 3/24/2026, the MDS indicated Resident 1's cognition (ability to think, reason, and function) was severely impaired. The MDS further indicated that Resident 1 was dependent on staff for toileting hygiene, showering/bathing, and lower body dressing, and required maximal assistance with eating, oral and personal hygiene, upper body dressing, bed mobility (movement), and transfers.During a review of Resident 1's Situation-Background-Assessment-Recommendation (SBAR - a communication tool used by healthcare workers when there is a change of condition among the residents) communication form dated 4/6/2026, timed at 6:50 p.m., the SBAR indicated that Resident 1 had an unwitnessed fall in the resident room, sustained a laceration to the back right side of the head, and was transferred to the hospital for further evaluation.During a review of Resident 1's SBAR communication form dated 4/9/2026, timed at 9:04 p.m., the SBAR indicated that Resident 1 had an additional fall.During a review of Resident 1's Nursing Progress Notes dated 4/9/2026 timed at 7:50 p.m., the Nursing Progress Notes further indicated that Resident 1 was found lying on the left lateral side next to the bed in the resident room.During a review of Resident 1's Fall Risk Evaluation dated 4/6/2026, the Fall Risk Evaluation indicated the following: Instructions: Evaluate the resident status in the eight clinical condition parameters listed below (A-H) by assigning the corresponding score which best describes the resident in the appropriate evaluation column. Add the column of numbers to obtain the Total Score. If the total score is 10 or greater, the resident should be considered at HIGH RISK for potential falls. A prevention protocol should be initiated immediately and documented on the care plan. To evaluate the resident's gait (a person's particular manner, style, or pattern of walking or running) and balance, have him/her stand on both feet without holding onto anything; walk straight forward; walk through a doorway; and make a turn. If nonapplicable (N/A), do not check any other boxes. The Fall Risk Evaluation dated 4/6/2026, the history of falls sections indicated that Resident 1 had no falls in the past three months despite the SBAR (dated 4/6/2026) documentation of a fall on the same date. (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Fall Risk Evaluation further indicated the gait and balance section of the 4/6/2026 evaluation did not indicate decreased muscular coordination, changes in gait pattern when walking through a doorway, or gait problems. However, it was marked with a score of one (1) for balance problem while standing, balanced problem while walking, and requires use of assistive devices. The Fall Risk Evaluation dated 4/9/2026, under the gait and balance section did not indicate decreased muscular coordination, changes in gait pattern when walking through a doorway, or gait problems. However, it was marked with a score of one (1) for balance problems while standing, balance problems while walking, and requires use of assistive devices (specialized tools, equipment, or technologies used to help residents maintain or improve their functional independence, safety, and mobility [movement]). During a concurrent interview and record review on 4/29/2026 at 5:10 p.m., with the Director of Nursing (DON), the DON reviewed Resident 1's Fall Risk Evaluations dated 4/6/2026 and 4/9/2026 and stated that the DON completed the Fall Risk Evaluations after the fall incidents occurred. The DON stated that the fall that occurred on 4/6/2026 was not reflected in the response to the history of falls section for the past three (3) months. The DON further stated that the gait and balance items - decreased muscular coordination, change in gait pattern, or gait problems were not marked because the resident had been transferred to the hospital via paramedics (a highly trained healthcare professional who provides advanced emergency medical care, stabilization, and transportation for patients in crisis situations, usually outside of a hospital), and the DON was unable to personally assess the resident's gait and balance at that time. The DON further stated that when completing Resident 1's Fall Risk Evaluation dated 4/9/2026, following the second fall, the DON obtained information from the rehabilitation therapy personnel that Resident 1 did not demonstrate issues related to decreased muscular coordination, change in gait pattern, or gait problems therefore, those items were not marked on the evaluation, and the DON left those items blank. When the DON was asked about the purpose of accurately completing the Fall Risk Evaluations, the DON stated that the assessments should be completed correctly to establish the development of individualized, person-centered care plans and to reduce each resident's risk for falls.During a review of the facility's policy and procedures (P&P) titled, Fall Risk and Prevention of Injury to include Pathological Fracture (broken bone caused by disease) last reviewed on 8/28/2025, the P&P indicated, It is the policy of the facility to identify that are at risk for falls to implement a plan of care in an attempt to prevent falls. Upon admission, a Fall Risk Assessment will be completed for all residents. The Fall Risk Assessment will be reviewed quarterly and after each fall. The incident report and the investigation will be reviewed by the Interdisciplinary Team (IDT - a group of different health professionals-such as doctors, nurses, therapists, and social worker who meet regularly to create a single, coordinated care plan for a resident) with recommendations for additional approaches to prevent further falls.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility's licensed nurses failed to accurately assess and complete dehydration (a condition that occurs when the body loses too much water and other fluids that it needs to work normally) risk assessments for one of four sampled residents (Resident 1).These deficient practices had the potential to place the residents at increased risk for dehydration.During a review of Resident 1's admission Record, the admission Record indicated that the facility originally admitted Resident 1 on 3/18/2026 and readmitted on [DATE] with diagnoses that included metabolic encephalopathy (ME - a disorder that affects brain function), dehydration, diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing), anemia (a condition where the body does not have enough healthy red blood cells), dementia (a progressive state of decline in mental abilities), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (paralysis or weakness on one side of the body) following cerebral infarction (stroke, loss of blood flow to a part of the brain resulting in damage to brain tissue), chronic kidney disease (a long-term condition where the kidneys are damaged and cannot effectively filter waste and extra fluid from the blood), and repeated falls.During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 3/24/2026, the MDS indicated Resident 1's cognition (ability to think, reason, and function) was severely impaired. The MDS further indicated that Resident 1 was dependent on staff for toileting hygiene, showering/bathing, and lower body dressing, and required maximal assistance with eating, oral and personal hygiene, upper body dressing, bed mobility (movement), and transfers.During a review of Resident 1's Dehydration Risk assessment dated [DATE], the Dehydration Risk Assessment indicated that the oral intake section was marked 75 percent (% - a way to express a part of a whole as a fraction out of 100) to 50%, and the total score was six (6), indicating Resident 1 was at moderate risk for dehydration.During a review of Resident 1's Dehydration Risk assessment dated [DATE], the Dehydration Risk Assessment indicated that the oral intake section was marked 100% to 75%, and the total score was two (2), indicating Resident 1 was at low risk for dehydration.During a concurrent interview and record review on 4/29/2026 at 4:20 p.m., with Registered Nurse 4 (RN 4), RN 4 reviewed Resident 1's Dehydration Risk assessment dated [DATE]. When asked how RN 4 obtained the information for the food intake and marked 75% to 50%, RN 4 stated that RN 4 based solely on observation of one meal consumed on the day of admission. RN 4 stated that this did not represent the resident's overall usual intake and that the additional information should have been obtained from the hospital records, or from the resident (if alert and oriented), or from family members. RN 4 stated that the documented intake was not accurate, as it was based on an assumption obtained from a single meal rather than comprehensive data. RN 4 stated that dehydration risk assessment should be completed using accurate and complete information in order to develop an appropriate plan of care and reduce the resident's risk for dehydrationDuring a concurrent interview and record review on 4/30/2026 at 3:57 p.m., with Registered Nurse 3 (RN 3), RN 3 reviewed Resident 1's Dehydration Risk assessment dated [DATE]. When asked how RN 3 obtained the information for the food intake and marked for 100% to 75% on the day of readmission, 4/23/2026, with a dehydration diagnosis, RN 3 stated that the intake range of 100% to 75% was documented without verification of the resident's actual intake. RN 3 stated that hospital records were not reviewed to obtain intake information, family members were unable to provide details regarding the resident's consumption during hospitalization, and the resident was unable to report intake amounts. RN 3 further stated that the accuracy of the documented oral intake could not be confirmed. The total score of the assessment was two (2), indicating a low risk for dehydration. RN 3 stated that accurate assessment of oral intake is necessary to establish an appropriate baseline and to develop and implement an individualized plan of care to reduce the risk of dehydration. During a review of the facility's policy and procedures (P&P) titled, Dehydration Risk (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assessment last reviewed on 8/28/2025, the P&P indicated, It is the policy of the facility to ensure that each resident is assessed for their hydration status on admission, within the assessment period, and at least quarterly. Each resident will be individually assessed to ensure sufficient intake to prevent dehydration.During a review of the facility's P&P titled, Hydration Management last reviewed on 8/28/2025, the P&P indicated, Residents will be screened on admission, quarterly, annually, and when there is a significant change of status for their hydration and nutritional status. While there is no reliable calculation to determine a resident's fluid needs, an assessment should take into consideration characteristics pertinent to each resident, such as age, medical diagnoses, activity level, etc. Residents identified with the potential for, or actual dehydration will be assessed for risk factors and appropriate recommendations shall be made. These risk factors and interventions will be documented on the plan of care.