

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555217	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2026
NAME OF PROVIDER OR SUPPLIER Pacifica Hospital of the Valley Dp Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 9449 San Fernando Road Sun Valley, CA 91352	
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 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on interview and record review, the facility failed to review and update their facility assessment at least annually. This deficient practice had the potential to result in residents not receiving necessary care and services in a timely manner due to the facility's failure to evaluate the resident population and identify the resources needed to provide appropriate care and services. Findings: During a concurrent interview and record review on 2/11/2026 at 8:25 a.m. with the Director of Staff Development (DSD), the document titled Facility Assessment Tool, updated 2/9/2026, was reviewed. The DSD stated the document Facility Assessment Tool was used to create a facility assessment during the week of 2/9/2026. During a concurrent interview and record review on 2/11/2026 at 3:34 p.m. with the Director of Nursing (DON) and DSD, the DSD and DON were unable to provide the previous facility assessment document or the date it was completed or last reviewed. The DSD stated he was not sure if a facility assessment had been completed in 2025. The DSD stated a staff member that last worked in the facility in 2024 was in charge of completing the facility assessment and no one had access to the last version of the facility assessment at this time. The DSD stated the facility did not have a policy or procedure regarding how and when to conduct a facility assessment. The DON stated the facility assessment should be completed regularly and should involve input from residents and their families so the residents can feel like they have a voice and the facility can be assessed as a whole. During an interview on 2/12/2026 at 11:22 a.m. with the DSD, the DSD stated the facility assessment should be updated yearly in case there are new issues or concerns so the facility can address and accommodate them.		

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 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on interview and record review, the facility failed to electronically submit staffing information based on payroll data to the Centers for Medicare & Medicaid Services (CMS) in the third quarter (4/1/2025-6/1/2025) of 2025. The deficient practice had the potential to not provide the required staffing to ensure residents' care and safety. Findings: During a concurrent interview and record review on 2/12/2026 at 11:40 a.m., with the Staffing Coordinator (SC), the 2025 Payroll-Based Journal (PBJ) Staffing Report for quarter 1 (10/1/2024-12/31/2024), quarter 2 (1/1/2025-3/31/2025), quarter 3 (4/1/2025-6/20/2025), and quarter 4 (7/1/2025-8/30/2025) were reviewed. The 2025 PBJ Staffing Report for quarter 3 was triggered for failing to submit data for the quarter. The SC stated it is a requirement to submit PBJ data quarterly. During an interview with Director of Staff Development (DSD) on 2/12/2026 at 12:08 p.m., the DSD stated the initial PBJ data submitted to CMS for quarter 3 did not go through because of an issue with the data file sent. The DSD stated the facility fixed the problem and resubmitted it, but it missed the deadline. The DSD stated the purpose of submitting PBJ data is to provide the number of staffing hours taking care of the residents. The DSD explained that when PBJ data is not submitted, the facility fails to show compliance with staffing hours which affects the facility's Centers for Medicare & Medicaid Services (CMS) star rating (evaluation of the quality and performance of nursing homes to help consumers compare facilities). During an interview on 2/12/2026 at 12:25 p.m., with the Director of Nursing (DON), the DON stated the facility does not have a policy regarding submission of PBJ staffing.		

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on interview and record review, the facility failed to maintain documentation and demonstrate evidence of an ongoing quality assurance and performance improvement (QAPI) program. This deficient practice increased the risk of failing to identify areas in which the facility needed to improve which had the potential to negatively impact the care residents received as well as their quality of life. Findings: During a concurrent interview and record review on 2/12/2026 at 11:22 a.m. with the Director of Nursing (DON) and Director of Staff Development (DSD), the facility's QAPI Minutes, dated 11/25/2025, 12/16/2025, and 1/29/2026, were reviewed. The DON stated these were the only documented QAPI meetings from the past year, as she started doing QAPI again after she was hired in the fall of 2025. The DON stated the importance of a well-developed QAPI program is to give department leaders time to discuss issues, identify potential gaps in care, and brainstorm ideas to implement in order to improve care for the residents. The DSD stated before the current DON started in the fall of 2025, there was a QAPI program, but it was not documented properly and there were only sign in sheets showing the staff that was present. The DSD stated the QAPI meetings should be documented so they know what they have discussed before in previous meetings and can continue to act on it. During a review of the facility's policy and procedure (P&P) titled, Quality Assurance and Performance Improvement (QAPI) Committee 2025, last reviewed 1/29/2026, the P&P indicated one goal of the QAPI committee is to establish, maintain, and oversee organizational systems and processes to support the delivery of quality of care and services. The P&P further indicated the committee shall maintain minutes of all meetings that include the date and time the committee met, the names of committee members present and absent, a summary of the reports and findings, a summary of any approaches and action plans to be implemented, conclusions and recommendations from the committee, and the time the meeting adjourned.		

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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 ensure staff followed transmission-based precautions (rules to prevent spreading infections) in accordance with facility policy and infection prevention standards to prevent the spread of infection, when the facility failed to ensure: 1.Licensed Vocational Nurse (LVN) 3 removed soiled gloves before pressing the call light reset button while giving morning care to Resident 55 who was on Enhanced Barrier Precautions (infection control steps requiring staff to wear gowns and gloves during high-contact care [like bathing, dressing, or changing catheters] for residents with, or at high risk of having, hard-to-treat germs) and did not pour visibly contaminated fluids into the shared sink in Resident 55's room. 2. Resident 22 did not have multiple disposable face masks hanging from the wheelchair or touching its wheels. 3. Infection outcomes were documented in the infection surveillance logs (a record-keeping tool used by nursing homes to track, analyze, and manage infections among residents). 4. Infection surveillance data is analysis (the ongoing, systematic collection and review of disease reports to track, understand, and stop the spread of infections) conducted and reports are generated at least quarterly, following facility policies and procedures (P&P). 5. The facility's Water Management Program ([WMP] - a written, step-by-step plan for buildings to ensure their water system was safe, clean, and efficient) was implemented and maintained as written. 6. Resident 13's bubble humidifier (a medical device that includes a plastic bottle partially filled with distilled water to add moisture to supplemental oxygen given to residents) was changed on 2/6/2026 as scheduled per physician orders. These failures placed residents, staff, and visitors at risk for exposure to and transmission of infectious organisms, incomplete monitoring and follow up of infections, missed trends or outbreaks due to lack of surveillance data analysis, contamination of equipment and unsafe water conditions. Findings: 1. During a review of Resident 55's Patient Registration Form, the Patient Registration Form indicated that Resident 55 was originally admitted to the facility on [DATE], then readmitted to the facility on [DATE]. During a review of the History and Physical (H&P) dated 4/2/2025, the H&P indicated Resident 55 was admitted to the facility with diagnoses including chronic traumatic encephalopathy following head injury (permanent brain damage that happens after many head injuries), history of seizure disorder (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness), respiratory failure (a condition where there's not enough oxygen or too much carbon dioxide in your body), tracheostomy (a surgically created hole in the neck that leads directly into the windpipe to help a person breathe), gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). During a review of Resident 55's Minimum Data Set ([MDS] - a resident assessment tool) dated 12/18/2025, the MDS indicated Resident 55 was comatose. Resident 55 was dependent (helper does all the effort) from staff with all activities of daily living (ADL), such as oral hygiene, toileting hygiene, personal hygiene, shower/bathe self, upper and lower body dressing. The MDS indicated that Resident 55 was dependent with roll left and right (ability to roll from laying on back to left and right side and return to laying on back on the bed). During a concurrent observation and interview on 2/9/2026 at 10:17 a.m. with LVN 3 in Resident 55's (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	room, observed LVN 3 and LVN 4 providing morning care to Resident 55. While doing so, Resident 55's head activated the touch pad call light (an alerting device for nurses or other nursing personnel to assist a patient when in need). LVN 3 was observed pressing the call light reset button without changing soiled gloves and then continuing morning care. LVN 3 stated that touching the call light reset button with contaminated gloves could lead to cross-contamination and spread of infection to residents, staff, and visitors. During a concurrent observation and interview on 2/9/2026 at 10:25 a.m. with LVN 3 in Resident 55's room, LVN 3 was observed disposing of visibly contaminated fluids into a shared sink after completing Resident 55's morning care. LVN 3 stated that disposing of contaminated water into a shared sink could contaminate the sink and surrounding surfaces, potentially spreading pathogens and increasing the risk of cross-contamination for residents, staff, and visitors. 2. During a review of Resident 22's Patient Registration Form, the Patient Registration Form indicated that Resident 22 was originally admitted to the facility on [DATE], then readmitted to the facility on [DATE]. During a review of the H&P dated 7/11/2025, the H&P indicated Resident 22 was admitted to the facility with diagnoses including chronic respiratory failure, tracheostomy, hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body). During a review of Resident 22's MDS dated [DATE], the MDS indicated Resident 22 was cognitively intact with little to no cognitive impairment. The MDS indicated Resident 22 was independent (resident completes the activity by themselves with no assistance from a helper) with oral hygiene, upper body dressing, lower body dressing, putting on/taking off footwear, personal hygiene. The MDS indicated the resident requires substantial/maximal assistance (helper does more than half the effort) with shower/bath. During a concurrent observation and interview on 2/10/2026 at 10:42 a.m. with Resident 22, Resident 22 was observed self-propelling in a wheelchair with multiple disposable face mask hanging from the wheelchair break handle. The masks were coming into contact with the wheelchair wheels. Resident 22 stated he takes extra disposable face masks from the nurses' station and keeps them on his wheelchair. Resident 22 further stated he changes masks frequently due to excessive mucus related to his tracheotomy. During an interview on 2/10/2026 at 10:45 a.m. with Registered Nurse (RN) 3, RN 3 stated disposable masks should not be hung on the wheelchair brake handle or touch the wheelchair wheels. RN 3 stated this could contaminate the masks. RN 3 further stated using potentially contaminated masks could increase the risk of infection for the resident. 3. During a concurrent interview and record review on 2/11/2026 at 11:15 a.m. with Infection Preventionist (IP), the facility's Infection Surveillance Logs indicated no documentation of outcomes for identified infections. IP stated that outcomes for identified infections should be documented in the infection surveillance log to ensure interventions and treatments are effective. 4. During a subsequent interview and record review on 2/11/2026 at 11:30 a.m. with IP, the IP stated she was unfamiliar with the Infection Surveillance Analysis and Reports and was not aware that Surveillance Analysis needed to be completed. Record review indicated the facility had no documented Infection Surveillance Analysis Reports. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	5. During a concurrent interview and record review on 2/12/2026 at 8:00 a.m. with Plant Operator Director (POD), the POD stated water temperatures are checked daily. The POD stated chlorine residual levels were not tested in the facility. The POD further stated the facility did not maintain a schedule for water testing and the facility did not have logs for water testing and the results as indicated in the facility's WMP. The POD stated failure to routinely test and document water quality, including chlorine residuals, may allow the growth and spread of waterborne pathogens (bacteria, viruses, or parasites found in contaminated water), which could place residents, staff and visitors at risk for waterborne infections (illnesses caused by bacteria, viruses, or parasites from human or animal waste that contaminate drinking or recreational water). During an interview on 2/12/2026 at 3:00 p.m. with Director of Nursing (DON), the DON stated the call light reset button was considered a high touch surface. The DON stated pressing the call light reset button with soiled gloves could lead to contamination of the surface and increase the risk of cross-contamination and the spread of pathogens to residents, staff and visitors. During a subsequent interview with DON on 2/12/2026 at 3:00 p.m., the DON stated disposing contaminated water into a resident's sink can contaminate the sink basin and surrounding surfaces. The DON stated that subsequent use of the contaminated sink for hand hygiene or resident care could expose residents and staff to pathogens, increase the risk of infections, leading to serious complications. The DON stated that infection surveillance logs should track the outcome, treatment response and follow up for each identified infection. The DON further stated without documenting infection outcomes in the surveillance logs the facility would not be able to determine if treatments are effective, if proper infection control processes are being followed, or if resident care interventions are meeting the residents' needs. The DON stated that it was the facility's policy to analyze infection surveillance data and generate reports and trends. The DON stated that failure to analyze surveillance data could affect the facility's ability to identify infection patterns or trends. The DON was uncertain about how often the surveillance data should be analyzed. The DON stated failure to follow the facility's WMP could compromise water quality, allow bacterial growth including Legionella (a type of bacteria found in water that can cause a severe, pneumonia-like lung infection), and result in residents being exposed to contaminated water, increasing the risk of waterborne infections. During a review of facility's P&P titled, Personal Protective Equipment (PPE) dated October 2025, the P&P indicated, Gloves shall be removed immediately and hands washed after each task was completed. If gloves are not removed, contamination of the environment, other patients, or other body sites on the same patient can occur. During a review of facility's P&P titled, Infection Control Plan 2025, dated May 2025, the P&P indicated, The Infection Preventionist will be responsible for data collection, evaluation and follow up. Surveillance data will be collected and recorded in the appropriate fashion. The Infection Preventionist will analyze and present the surveillance data to the Infection Control Committee and appropriate medical staff committees at least quarterly. During a review of facility's P&P titled, Isolation Precautions, dated May 2025, the P&P indicated, Use Standard Precautions for the care of all patients. Handle used patient care equipment soiled with blood, body fluids, secretions and excretions in a manner that prevents skin and mucous membrane exposures, contamination of clothing and transfer of microorganisms to other patients and environments. During a review of facility's WMP, dated January 2024, the WMP indicated, Control measures and (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	limits have been established to limit growth and spread of Legionella, such as maintaining domestic hot water temperatures in the storage tanks, hot water return temperatures, frequent flushing of hot water faucets and Pacifica Hospital - Water Management Plan (January 2024 updated) Page 9 of 13 showers in low-use area, maintaining chemicals in cooling tower to inhibit bacteria growth, monitoring hot water temperatures at distal locations throughout all buildings, and monitoring residual monochloramine levels in the cold water distal locations. 6. During a review of Resident 13's admission Record (the front page of the chart that contains a summary of basic information about the resident), the admission Record indicated the facility admitted Resident 13 to the facility on [DATE]. During a review of the History and Physical (H&P) Note completed on 9/21/2023, the H&P indicated Resident 13 was admitted to the facility with diagnosis that included chronic hypoxemic respiratory failure (a long-term condition where the lungs cannot sufficiently transfer oxygen into the blood), cerebral vascular accident (CVA &stroke, loss of blood flow to a part of the brain), and post percutaneous endoscopic gastrostomy (PEG &medical device inserted into the stomach to provide essential nutrition, fluids, and medication or require long term feeding). The H&P indicated Resident 13 is unable to make decisions. During a review of Resident 13's Minimum Data Set (MDS &a resident assessment tool), dated 12/19/2025, the MDS indicated Resident 13 rarely/never able to make self-understood and rarely/never able to understand others. The MDS indicated Resident 13 was dependent (helper does all of the effort) with oral hygiene, toileting hygiene, personal hygiene, shower/bathe self, upper and lower body dressing. During an observation on 2/9/2026 at 8:33 a.m. at Resident 13's bedside, a bubble humidifier dated 2/4 was observed connected to Resident 13's oxygen tubing. During an interview on 2/9/2026 at 11:13 a.m. with Respiratory Therapist (RT), RT 1 stated the date on the bubble humidifier indicates when it was last changed. RT 1 stated that Resident 13's bubble humidifier was dated 2/4, indicating that it was last changed on 2/4/2026 and had not been changed on 2/6/2026 as scheduled per physician orders. During a review of Resident 13's Order Summary Report, dated 2/11/2026, the Order Summary Report indicated a physician's order on 12/18/2023 to change the bubble humidifier in the morning every Monday, Wednesday, and Friday. During a review of Resident 13's MAR dated February 2026, the MAR indicated that on 2/6/2026 for the 9 am administration time, there were staff initials in the box for the order to change bubble humidifier in the morning of every Monday, Wednesday, and Friday, indicating the task had been completed. During an interview on 2/12/2026 at 11:19 a.m. with RT 2, RT 2 stated he documented on Resident 13's MAR on 2/6/2026 at 9am that he changed the bubble humidifier before he went to Resident 13's bedside to perform the task. RT 2 explained that when he went to Resident 13's bedside, Resident 13 was occupied and receiving care from another staff. RT 2 stated he did not change the bubble humidifier and meant to return later but forgot. RT 2 stated, It slipped my mind. RT 2 stated the bubble humidifier was not changed at all on 2/6/2026 as ordered. RT 2 stated it is important to change the bubble nebulizer regularly as scheduled to prevent bacterial or any other unwanted growth. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the facility's P&P titled, Infection Control Plan 2025 last reviewed 1/29/2026, the P&P indicated, the facility is to maintain a comprehensive and effective program of surveillance, prevention, and control of infection .The organization will employ a coordinated process to reduce the risks of endemic, and epidemic, or healthcare-related infections(s) in patients and healthcare workers.Risk Mitigation: Practices to Decrease the Risk of Transmission.Adherence to appropriate infection prevention measures (e.g. hand hygiene, barrier precautions, aseptic techniques).		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 dignity and respect for four out of four sampled residents (Residents 1, 30, 49, and 64) when: 1. The facility failed to ensure Resident 1's Foley catheter (a specific type of tube inserted into the bladder to help drain urine) collection bag (designed to collect urine drained from the bladder via catheter) was covered with a dignity bag (a bag used to cover and hold the catheter drainage/collection bag, so it is not visible). 2. The facility failed to ensure a Restorative Nursing Assistant (RNA 1) knocked or requested permission before entering Resident 30's room. 3. LVN 2 failed to provide privacy while administering medications through Resident 49's gastrostomy tube (g-tube, a medical device inserted directly into the stomach through the abdomen to deliver nutrition, fluids, and medication). 4. The facility failed to honor Resident 64's right to be informed and involved in his care planning, when the resident was not provided with ongoing information regarding the status of his requested transfer to another facility. These deficient practices violated the residents' rights to be treated with respect and dignity and had the potential to negatively affect the residents' sense of self-worth and self-esteem. Findings: 1. During a review of Resident 1's admission Record (the front page of the chart that contains a summary of basic information about the resident), the admission Record indicated the facility admitted Resident 1 to the facility on [DATE]. During a review of the History and Physical (H&P) report completed on 12/1/2025, the H&P indicated Resident 1 was admitted to the facility with diagnoses that included acute hypoxemic respiratory failure (a medical emergency where the lungs suddenly cannot transfer enough oxygen into the bloodstream to preserve normal organ function), diabetes mellitus (a chronic condition that affects the way the body processes blood sugar), and history of urinary tract infection (UTI &ndash; an infection of the urinary system, which includes the kidneys, ureters, bladder and urethra). During a review of Resident 1's Minimum Data Set (MDS &ndash; a resident assessment tool), dated 12/12/2025, the MDS indicated Resident 1 rarely/never able to make self-understood and rarely/never able to understand others. The MDS indicated Resident 1's cognitive skills for decision making are severely impaired (never/rarely made decisions). The MDS indicated Resident 1 was dependent (helper does all of the effort) with oral hygiene, toileting hygiene, personal hygiene, shower/bathe self, upper and lower body dressing. During an observation on 2/10/2026 at 4:05 p.m., Resident 1's Foley catheter collection bag was attached to the side of the bed rail, with the urine visible inside. The urine collection bag was observed to be attached to a dignity bag, with the collection bag placed outside of the dignity bag. During a concurrent observation and interview on 2/10/2026 at 4:10 p.m. with Licensed Vocational Nurse (LVN) 1 in Resident 1's room, LVN 1 stated the urine collection bag observed outside the dignity bag should be inside the dignity bag. LVN 1 explained the purpose of the dignity bag is to hide the urine draining from the resident from other people's view. LVN 1 stated that privacy is a resident's right and the dignity bag provides privacy. During a review of Resident 1's Order Summary Report, dated 2/11/2026, the Order Summary Report indicated a physician's order on 11/29/2025 for Foley catheter size 16x10 every shift for wound (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	management During an interview on 2/12/2026 at 12:25 p.m. with the Director of Nursing (DON), the DON stated that dignity bags are expected to be used for all residents with foley catheters. During a review of the facility's P&P titled, Patient's Rights - Residents last reviewed 1/29/2026, the P&P indicated, It is the policy of the Patient Care Services, Subacute Units, to have policies and procedures on residents' rights to ensure that each resident is able to fully exercise his or her rights as resident and as a citizen. Ensuring that residents are afforded these rights contribute to their quality of life and this to the overall quality of care provided in the facility.5. This facility shall treat each resident with consideration, respect, and full recognition of his/her dignity and individuality. 2. During a review of Resident 30's Patient Registration Form, the Patient Registration Form indicated the facility admitted the resident on 8/28/2021. During a review of Resident 30's History and Physical (H&P) dated 2/9/2026, the H&P indicated Resident 30 had the diagnoses of tracheostomy (surgically created opening in the front of the neck leading directly into the trachea [windpipe] to help a person breathe) with ventilator (a machine that helps you breathe) dependence and cerebral vascular accident (CVA-stroke, loss of blood flow to a part of the brain). The H&P further indicated Resident 30 was unable to make his own decisions. During a review of Resident 30's MDS, the MDS indicated the resident rarely/never understood others and rarely/never made themselves understood. The MDS further indicated Resident 30 was completely dependent (helper does all the effort) on staff for all activities of daily living (ADLs-activities such as bathing, dressing and toileting a person performs daily). During an observation and interview on 2/9/26 at 9:57 a.m., in the hallway near the entrance of Resident 30's room with RNA 1, RNA 1 was observed entering Resident 30's room without knocking on the door and asking permission to go in. At this time Resident 30 was on his bed. Upon exiting the room and when interviewed, RNA 1 stated she forgot to knock on the resident's room and stated that she should have knocked and asked permission to go in since this is the resident's home and they deserve privacy. During an interview on 2/10/26 at 11:26 a.m. with the Director of Nursing (DON), the DON stated that anyone entering a resident's room must knock and ask permission prior to entering the resident's room. The DON stated resident's privacy should be respected to avoid embarrassment. The DON stated that residents should be treated with respect and dignity. During a review of the facility's policy and procedure (P&P) titled Patient's Rights - Residents, last reviewed on 1/29/2026, the P&P indicated that the facility shall treat each resident with respect and full recognition of dignity and staff will knock prior to entering the room. 3. During a review of Resident 49's Patient Registration Form, the Patient Registration Form indicated the facility admitted the resident on 2/18/2022. During a review of Resident 49's History and Physical (H&P), dated 7/11/2025, the H&P indicated Resident 49 had diagnoses including, but not limited to, chronic (long-term) respiratory failure (a condition where the lungs cannot release enough oxygen into the blood), was dependent on a ventilator (a medical device to help support or replace breathing), and required a g-tube to receive (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Pacifica Hospital of the Valley Dp Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 9449 San Fernando Road Sun Valley, CA 91352	
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	nutrition. The H&P further indicated Resident 49 had an impaired mental status and was unable to make decisions. During a review of Resident 49's Minimum Data Set (MDS &ndash; a resident assessment tool), dated 11/14/2025, the MDS indicated Resident 49 was in a persistent vegetative state (a disorder of consciousness following severe brain injury where the person is awake but completely unaware of themselves or their environment) and was dependent (helper does all of the effort) for all activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a concurrent observation and interview on 2/11/2026 at 8:45 a.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 entered Resident 49's shared room to administer medications via her g-tube. LVN 2 closed the resident's curtain to the resident's left side but left the foot of the bed and the resident's right side exposed. LVN 2 then lifted the resident's gown exposing her abdomen and g-tube and began administering medications. LVN 2 stated the resident should have been provided privacy during medication administration. LVN 2 stated residents should be given privacy because it is one of their basic rights. During an interview on 2/11/2026 at 3:34 p.m. with the Director of Nursing (DON) and Director of Staff Development (DSD), the DON stated the resident should have been provided privacy during medication administration. The DON stated residents have the right to privacy, and they may not want anyone else to know they have a g-tube. The DSD stated residents deserve dignity and should be given privacy when being exposed. During a review of the facility's policy and procedure (P&P) titled, Patient's Rights - Residents, last reviewed 1/29/2026, the P&P indicated the facility shall treat each resident with consideration, respect, and full recognition of his/her dignity and individuality. The P&P further indicated all treatments and personal care are given in privacy. 4. During a review of Resident 64's Patient Registration Form, the Patient Registration Form indicated the facility originally admitted the resident on 4/18/2025 and readmitted to the facility on [DATE]. During a review of Resident 55's H&P dated 4/2/2025, the H&P indicated Resident 55 was admitted to the facility with diagnoses including chronic respiratory failure (a condition where there's not enough oxygen or too much carbon dioxide in your body), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), history of deep venous thrombosis ([DVT] - a serious medical condition where a blood clot forms in a deep vein), history of pulmonary embolism (a sudden, often life-threatening blockage in one or more arteries in the lungs). During a review of Resident 64's MDS, the MDS indicated Resident 64 was cognitively intact (able to make clear decisions). The MDS indicated that Resident 64 was dependent (helper does all the effort) from staff with toileting hygiene, shower, upper and lower body dressing, putting on/taking off footwear and personal hygiene. The MDS indicated that Resident 64 was dependent with sit to stand (the ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed) and chair/bed-to-chair transfer (he ability to transfer to and from a bed to a chair (or wheelchair). During an interview on 2/9/2026 at 9:30 a.m. with Resident 64, Resident 64 expressed dissatisfaction with the lack of communication regarding his care plan and transfer process. Resident 64 stated that he informed the social worker of his request to be transferred to a facility closer to his family approximately two months ago. Resident 64 stated he had not received any updates or information (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	about the status of his request. During a concurrent interview and record review on 2/10/2026 at 3:35 p.m. with Social Worker (SW) 1, Resident 64's Social Service Notes for January and February 2026 were reviewed. The Social Service Notes indicated no documentation that Resident 64 was provided with information about the transfer referrals and was updated on the status of the transfer process. SW 1 stated the transfer process in progress had not been communicated to Resident 64. SW 1 stated it is Resident 64's right to be informed and updated regarding his care plan. During an interview on 2/12/2026 at 3:00 p.m. with Director of Nursing (DON), the DON stated it was the facility's policy to review and communicate care plan updates with residents and resident representatives. The DON stated residents have the right to be informed, and that staff were expected to discuss care plan updates and obtain the residents' input when changes occur. The DON further stated that residents and their families should be involved in care planning and kept aware of progress of all aspects of care. During a review of facility's policies and procedures (P&P) titled, Patient's Rights & Residents dated December 2025, the P&P indicated, This facility shall recognize and respect individuality of each resident and encourage expression of capabilities and independence. Therefore, compliance with the Federal and State regulations for residents' rights shall be maintained and utilized to enhance the comfort and wellbeing of each patient. Failure to ensure these rights will not be tolerated by facility management.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation, interview, and record review, the facility failed to provide an environment that was free from accident hazards for three of four residents (Residents 44, 29 and 55) reviewed under the accident care area by failing to: a. Provide upper bed rail padding for Resident 44, who had a history of seizures (a sudden surge of abnormal electrical activity in the brain, leading to a range of symptoms like muscle spasms, loss of consciousness). b. Apply bed side rail padding for seizure (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness) precautions as ordered by the physician for Resident 29. c. Ensure implementation of appropriate seizure precautions for Resident 55 with a documented history seizure disorder, as Resident 55 was observed with side rail up without padding and had no order for padded side rails. These deficient practices placed Residents 44, 29 and 55 at risk of injury and trauma during seizures. Findings: a. During a review of Resident 44's Patient Registration Form, the Patient Registration Form indicated the facility admitted Resident 44 on 3/27/2025. During a review of Resident 44's History and Physical (H&P), dated 1/26/2026, the H&P indicated Resident 44's had diagnoses including seizures assessment plan included seizures and tracheostomy (surgically created opening in the front of the neck leading directly into the trachea [windpipe] to help a person breathe). The H&P further states Resident 44 was unable to make his own decisions. During a review of Resident 44's Minimum Data Set (MDS &ndash; an assessment and care screening tool) dated 11/20/2025, the MDS indicated the resident rarely/never understood others and rarely/never made themselves understood. The MDS further indicated Resident 44 was completely dependent (helper does all the effort) on facility staff for all activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 44's Physician's Order printed on 2/11/2026, the Physician's Order indicated an order dated 5/20/2025, for bilateral padded side rails up at all times. During an observation on 2/9/2026 at 9:26 a.m. in Resident 44's room, Resident 44 was lying in bed with his eyes closed. The upper bed rails on Resident 44's bed were made of metal and were not padded. During a concurrent observation and interview on 2/9/2026 at 9:33 a.m. in Resident 44's room with Registered Nurse (RN 1), RN 1 stated Resident 44's bed did not have the necessary padding on his bedrails to keep him safe during a seizure. RN 1 stated the padding is to protect the resident's head and body from the uncontrolled shaking from seizures. During an interview on 2/9/2026 at 1:45 p.m. with the Director of Nursing (DON), the DON stated the facility staff did not follow the physician's instructions to apply padding to Resident 44's side rails and without them Resident 44 could sustain injuries if he had seizure. During a review of the facility provided Policy and Procedure (P&P) titled, Seizure Precautions last reviewed on 1/29/2026, the P&P indicates to provide a safe environment and pad side rails as indicated. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. During a review of Resident 29's Patient Registration Form, the Patient Registration Form indicated Resident 29 was admitted to the facility on [DATE]. During a review of the H&P report dated 12/10/2025, the H&P indicated Resident 29 was admitted to the facility with diagnoses including chronic respiratory failure with hypoxia (a condition where there's not enough oxygen or too much carbon dioxide in your body), seizure disorder (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness), traumatic subdural hemorrhage (a head injury causes blood vessels to tear and leak blood between the brain and its outer covering), dysphagia (difficulty swallowing). During a review of Resident 29's MDS dated [DATE], the MDS indicated Resident 29 had moderate cognitive impairment (decisions poor; cues/supervision required). The MDS indicated Resident 29 was dependent (helper does all the effort) from staff with all activities of daily living (ADL), such as oral hygiene, toileting hygiene, personal hygiene, shower/bathe self, upper and lower body dressing. The MDS indicated that Resident 29 was dependent with chair/bed-to-chair transfer (the ability to transfer to and from a bed to a chair (or wheelchair)). During a review of Resident 29's Order Summary Report dated 5/5/2024, the Order Summary Report indicated physician order for bilateral (two sides) padded side rails at all times every shift. During a concurrent observation and interview on 2/10/2026 at 2:04 p.m. with Licensed Vocational Nurse (LVN) 6 in Resident 29's room, Resident 29's bed was observed with all 4 side rails up with no padding. LVN 6 stated Resident 29 was at risk for seizures. LVN 6 stated Resident 29 was at risk for seizures, and that lack of padding could result in head injury or trauma during a seizure. c. During a review of Resident 55's Patient Registration Form, the Patient Registration Form indicated that Resident 55 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE]. During a review of the H&P dated 4/2/2025, the H&P indicated Resident 55 was admitted to the facility with diagnoses including chronic traumatic encephalopathy following head injury (permanent brain damage that happens after many head injuries), history of seizure disorder (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness), respiratory failure (a condition where there's not enough oxygen or too much carbon dioxide in your body), tracheostomy (a surgically created hole in the neck that leads directly into the windpipe to help a person breathe), gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). During a review of Resident 55's MDS dated [DATE], the MDS indicated Resident 55 was comatose. Resident 55 was dependent from staff with all ADLs, such as oral hygiene, toileting hygiene, personal hygiene, shower/bathe self, upper and lower body dressing. The MDS indicated that Resident 55 was dependent with roll left and right (ability to roll from laying on back to left and right side and return to lying on back on the bed). (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	^ During a concurrent interview and record review on 2/10/2026 at 2:08 p.m. with LVN 6 of Resident 55's Care Plan Report dated 6/20/2026 indicated bilateral padded side rails were to remain up all times for seizure precautions. However, the Physician Order Summary did not indicate documentation of an order to maintain padded side rails up at all times for seizure precautions. LVN 6 stated Resident 55 had a history of seizure disorder. ^ During a concurrent observation and interview on 2/10/2026 at 2:10 p.m. with LVN 6 in Resident 55's room, Resident 55's bed observed having 4 siderails up with no padding on any of the siderails. LVN 6 stated without an order and padding in place, Resident 55 could be at increased risk for head injury or trauma in the event of seizures. ^ During an interview on 2/12/2026 at 3:00 p.m. with Director of Nursing (DON), the DON stated that Residents 29, 44, and 55 were on seizure precautions. The DON stated that seizure precautions should follow the physician's orders and individualized assessments. The DON stated that failure to follow ordered interventions and implement seizure precautions, including padded side rails when indicated, could place residents at serious risk of harm. The DON added that unpadded side rails during a seizure could cause injuries such as head trauma, fractures, skin breakdown or even death. ^ During a review of the facility's policy and procedure (P&P) titled, Seizure Precautions, reviewed/revised on December 2025, the P&P indicated, It is the policy of the facility to provide preventative measures prior to and during seizure activity to prevent resident injury to the extent possible. Identify residents with potential for seizure activity on the resident's care plan. Provide safe environment. Pad side rails as indicated.		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to safely use side rails for five of six sampled residents (Resident 6, 8, 24, 29, 55) by failing to: 1. Having a physician's order for Resident 55 and Resident 6's use of side rails and follow the physician's order for bilateral side rails up at all times, when all four side rails were observed up. 2. Assess Residents 6, 8, 24, 29, and 55 for risk of entrapment from bed rails prior to installation and obtain informed consent prior to use of side rails. These deficient practices had the potential to result in the restriction of residents' freedom of movement, a decline in physical functioning, psychosocial harm (mental, emotional, or physical injuries caused by social factors, or stressful interactions, rather than physical accidents), physical harm and risk for entrapment (getting stuck). Findings: a. During a review of Resident 6's Patient Registration Form, the Registration Form indicated the facility admitted the resident on 6/3/2022. During a review of Resident 6's History and Physical (H&P), dated 1/26/2026, the H&P indicated Resident 6 had diagnoses including tracheostomy (surgically created opening in the front of the neck leading directly into the trachea [windpipe] to help a person breathe). and dysphagia (difficulty swallowing). The H&P further indicated Resident 6 did not have the capacity to make his own decisions. During a review of Resident 6's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 1/8/2026, the MDS indicated Resident 6 had some cognitive decline but is able to make himself understood and understand others. During a review of Resident 6's Order Summary Report, the report included and order dated 6/3/2026 for bilateral side rails up at all times every shift. During a review of Resident 6's Side Rails Care Plan (CP), initiated on 6/27/2026, the CP had an intervention to use side rails as indicated. During an observation on 2/9/2026, at 9:58 a.m., inside Resident 6's room, Resident 6 was sitting up in bed with four side rails up (upper and lower). During a concurrent observation and interview on 2/9/2026, at 10:33 a.m., inside Resident 6's room with Registered Nurse (RN 1), RN 1 looked at the bed rails and stated four side rails are up, but that she believed it should be only two. During a concurrent interview and record review on 2/9/2026 at 1:05 p.m. with RN 1, RN 1 reviewed Resident 6's electronic and paper medical record. RN 1 stated there was an order for only bilateral (two) side rails up and all four should not have been up for Resident 6's safety. RN 1 searched and stated there was not a consent for the use of bed rails or an assessment for entrapment. RN 1 stated residents should be assessed for entrapment to prevent injuries, and the responsible party should have the opportunity to consent for the use of side rails after being informed of the risks and benefits prior to use. (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/10/2026, at 10:08 a.m., with the Director of Nursing (DON), the DON stated prior to installation of the side rails on the resident's bed they should have had a physician's order, consent for the use of the bedrail, and assessment for entrapment, to ensure appropriate use and safe use of the bedrail for the residents. During a review of the facility's recent policy and procedure (P&P) titled, Side Rail Assessment, last reviewed on 1/29/2026, the P&P indicated a siderail assessment was to be completed every 3 months. During a review of the facility's recent policy and procedure (P&P) titled, Informed Consent, last reviewed on 1/29/2026, the P&P indicated there must be a signed a signed consent for all treatments and procedures. During a review of the facility's recent policy and procedure (P&P) titled, Orders, Physicians, last reviewed on 1/29/2026, the P&P indicated accuracy must be assured with all physician's orders. b. During a review of the History and Physical (H&P) dated 12/19/2025, the H&P indicated Resident 8 was admitted with diagnoses including cardiopulmonary arrest (a medical emergency where the heart suddenly stops beating, stopping blood flow to the brain and body), respiratory failure (a condition where there's not enough oxygen or too much carbon dioxide in your body), encephalopathy (damage or disease that affects the brain), hypertension (high blood pressure), Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). Resident 8 was comatose (a state of deep, prolonged unconsciousness where a person cannot be awakened, fails to respond to light, sound, or pain, and does not move voluntarily) and totally unresponsive to verbal and painful stimuli. During a review of Resident 8's Minimum Data Set ([MDS] - a resident assessment tool) dated 12/24/2025, the MDS indicated Resident 8 was comatose. Resident 8 was dependent (helper does all the effort) from staff with all activities of daily living (ADL), such as oral hygiene, toileting hygiene, personal hygiene, shower/bathe self, upper and lower body dressing. The MDS indicated that Resident 8 was dependent with rolling left and right (ability to roll from laying on back to left and right side and return to lying back on the bed). During an observation on 2/9/2026, at 12:10 p.m., in Resident 8's room, Resident 8 was lying down in bed with four side rails up (upper and lower). During a review of Resident 8's Order Summary Report dated 2/26/2025, the Order Summary Report indicated physician order for bilateral (two sides) side rails up at all times every shift. During a concurrent observation and interview on 2/10/2026 at 2:10 p.m. with Licensed Vocational Nurse (LVN) 6 and Registered Nurse (RN) 4 in Resident 8's room, Resident 8's bed was observed having four side rails up. LVN 6 stated four side rails were up to prevent Resident 8 from falling. c. During a review of Resident 24's Patient Registration Form, the Patient Registration Form indicated Resident 24 was admitted to the facility on [DATE]. During a review of Resident 24's H&P dated 10/13/2025, the H&P indicated Resident 24 was admitted to the facility with diagnoses including traumatic encephalopathy following head injury(permanent brain damage that happens after many head injuries), history of respiratory failure (a condition where (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	there's not enough oxygen or too much carbon dioxide in your body), permanent tracheostomy (a surgically created hole in the neck that leads directly into the windpipe to help a person breathe), seizure disorder (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness). The H&P indicated Resident 24 was awake, responsive, able to verbalize slightly. During a review of Resident 24's Minimum Data Set ([MDS] - a resident assessment tool) dated 12/4/2025, the MDS indicated Resident 24 had moderately impaired cognitive skills (decisions poor; cues/supervision required). The MDS indicated Resident 24 was dependent (helper does all the effort) from staff with all activities of daily living (ADL), such as oral hygiene, toileting hygiene, personal hygiene, shower/bathe self, upper and lower body dressing. The MDS indicated that Resident 24 was dependent with roll left and right (ability to roll from laying on back to left and right side and return to laying on back on the bed). During an observation on 2/9/2026, at 12:15 p.m., in Resident 24's room, Resident 24 was lying down in bed with four side rails up (upper and lower). During a review of Resident 24's Order Summary Report dated 12/22/2025, the Order Summary Report indicated a physician order for bilateral padded side rails for seizure precautions every shift. During a concurrent observation and interview on 2/10/2026 at 2:04 p.m. with LVN 6 and RN 4 in Resident 24's room, Resident 24's bed was observed having 4 side rails up with no padding. LVN 6 stated four side rails were up to prevent Resident 24 from falling. LVN 6 stated Resident 24 was at risk for seizures, and that lack of padding could result in head injury or trauma during a seizure episode. d. During a review of Resident 29's Patient Registration Form, the Patient Registration Form indicated Resident 29 was admitted to the facility on [DATE]. During a review of the H&P report dated 12/10/2025, the H&P indicated Resident 29 was admitted to the facility with diagnoses including chronic respiratory failure with hypoxia (a condition where there's not enough oxygen or too much carbon dioxide in your body), seizure disorder (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness), traumatic subdural hemorrhage (a head injury causes blood vessels to tear and leak blood between the brain and its outer covering), dysphagia (difficulty swallowing). During a review of Resident 29's MDS dated [DATE], the MDS indicated Resident 29 had moderate cognitive impairment. The MDS indicated Resident 29 was dependent from staff with all ADL, such as oral hygiene, toileting hygiene, personal hygiene, shower/bathe self, upper and lower body dressing. The MDS indicated that Resident 29 was dependent with chair/bed-to-chair transfer. During an observation on 2/9/2026, at 12:20 p.m., in Resident 29's room, Resident 29 was lying down in bed with four side rails up (upper and lower) with no padding. During a review of Resident 29's Order Summary Report dated 5/5/2024, the Order Summary Report indicated physician order for bilateral (two sides) padded side rails at all times every shift. During a concurrent observation and interview on 2/10/2026 at 2:04 p.m. with Licensed Vocational Nurse (LVN) 6 in Resident 29's room, Resident 29's bed was observed with all 4 side rails up with no (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	padding. LVN 6 stated four side rails were up to prevent Resident 29 from falling. LVN 6 stated Resident 29 was at risk for seizures, and that lack of padding could result in head injury or trauma during a seizure. e. During a review of Resident 55's Patient Registration Form, the Patient Registration Form indicated that Resident 55 was originally admitted to the facility on [DATE], then readmitted to the facility on [DATE]. During a review of the H&P dated 4/2/2025, the H&P indicated Resident 55 was admitted to the facility with diagnoses including chronic traumatic encephalopathy following head injury (permanent brain damage that happens after many head injuries), history of seizure disorder (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness), respiratory failure (a condition where there's not enough oxygen or too much carbon dioxide in your body), tracheostomy (a surgically created hole in the neck that leads directly into the windpipe to help a person breathe), gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). During a review of Resident 55's MDS dated [DATE], the MDS indicated Resident 55 was comatose. Resident 55 was dependent from staff with all ADLs, such as oral hygiene, toileting hygiene, personal hygiene, shower/bathe self, upper and lower body dressing. The MDS indicated that Resident 55 was dependent with roll left and right (ability to roll from laying on back to left and right side and return to lying on back on the bed). During an observation on 2/9/2026, at 12:20 p.m., in Resident 55's room, Resident 55 was lying down in bed with four side rails up (upper and lower) with no padding. During a concurrent interview and record review on 2/10/2026 at 2:06 p.m. with LVN 6 of Resident 55's Care Plan Report dated 6/20/2026, the Care Plan Report indicated bilateral padded side rails were to remain up all times for seizure precautions. However, the Physician Order Summary did not indicate documentation of an order to maintain padded side rails up at all times for seizure precautions. LVN 6 stated Resident 55 had a history of seizure disorder. During a concurrent observation and interview on 2/10/2026 at 2:07 p.m. with LVN 6 in Resident 55's room, Resident 55's bed was observed having 4 siderails up with no padding on any of the siderails. LVN 6 stated without an order and padding in place, Resident 55 could be at increased risk for head injury or trauma in the event of seizures. During a concurrent interview and record review on 2/10/2026 at 2:10 p.m. with RN 4, RN 4 reviewed Resident 24, Resident 8, Resident 29 and Resident 55's electronic and paper medical records. RN 4 stated there was an order for bilateral padded side rails up for seizure precautions and having four side rails raised without padding was not according to the physician's order for Resident 24, 8, 29 and 55. RN 4 stated there was no documented entrapment risk assessment and no documented consent for the use of bed rails. RN 4 stated this practice had the potential to place Resident 24, 8, 29 and 55 at risk for injury and entrapment. RN 4 further stated residents/RP should have the opportunity to consent for side rails to ensure the benefits outweigh the risks. During an interview on 2/12/2026 at 3:00 p.m. with Director of Nursing (DON), the DON stated side rails must have doctors order before they are used. The DON stated that if a physician's order (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indicates bilateral side rails, staff should not raise all four side rails by default. Using all four side rails considered a restraint. The DON stated it was not acceptable to maintain side rails up at all times without documented consent from the residents or RP. Residents/RPs must be aware of possible risks, benefits, and other available options. The DON added that the facility must assess residents for entrapment risk or admission, at least quarterly, and on an ongoing basis. If residents become trapped between mattress and the side rail, it can lead to serious harms and even death. During a review of the facility's recent policy and procedure (P&P) titled, Side Rail Assessment, last reviewed on 1/29/2026, the P&P indicated a siderail assessment was to be completed every 3 months. During a review of the facility's policy and procedure (P&P) titled, Informed Consent for Procedures and Treatments, reviewed in December 2025, the P&P indicated there must be a signed consent*for all treatments and procedures. During a review of the facility's P&P titled, Orders, Physicians, reviewed in December 2025, the P&P indicated accuracy must be assured with all physician's orders.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to: 1. Have immediate access to controlled substances ([CS] - medications which have a potential for abuse and may also lead to physical or psychological dependence, also known as narcotics or Controlled Medication [CM]) and medication emergency kit ([eKIT] - kit containing medications needed to be used during emergencies) stored in the refrigerator in one (1) of two (2) observed Medication Rooms (Medication Room Subacute 2.) 2. Include the verifying signatures of two (2) licensed nurses on the Facility Medication Destruction Form observed in Medication Room Subacute 2, for four (4) of four (4) sampled records. As a result, control and accountability of medications disposition (process of returning and/or destroying unused medications) did not follow state and federal regulations and facility policy and procedures. 3. Reconcile (the process of comparing transactions and activity to supporting documentation) two (2) medication eKITs containing CSs for February 2026, in two (2) of two (2) inspected Medication Rooms (Medication Room Subacute 2 and Medication Room Subacute 3.) As a result, control and accountability of CSs did not follow state and federal regulations and facility policy and procedures. 4. Complete an accurate CS reconciliation at shift change on 2/9/2026 in one (1) of three (3) observed Medication Carts (Medication Cart Subacute 2 Cart 2.)^ As a result, control and accountability of CSs did not follow facility policy and procedures. These deficient practices increased the opportunity for medication diversion (the transfer of a medication from a lawful to an unlawful channel of distribution or use,) and increased the risk that residents in the facility could have accidental exposure to harmful medications and delayed medication treatment during emergencies possibly leading to physical and psychosocial harm, and hospitalization. Findings: During a concurrent observation and interview on 2/9/2026 at 11:30 a.m., with Registered Nurse (1), in Medication Room Subacute 2, RN 4 could not open the double locks on a plastic clear rectangular container inside the refrigerator. RN 4 stated the container with the double lock contained CSs for several residents and an eKIT. RN 4 asked several other nurses to open the locks but none of the keys opened the container. The pharmacy department and engineering departments were called to assist in opening the container. During a concurrent record review and interview on 2/9/2026 at 11:40 a.m., with RN 4, in Medication Room Subacute 2, RN 4 reviewed four (4) Facility Medication Destruction Form records dated 1/2/2026 and 2/9/2026. RN 4 stated RN 4 was unable to locate the signatures or names of the licensed nurses on the four (4) logged disposition records. RN 4 stated that licensed nurses failed to follow state requirements and facility policy of signing the logs with a witness when disposing medications. During a review of Facility Medication Destruction Form, dated 1/2/2026, 1/2/2026, 2/9/2026 and 2/9/2026, the four (4) forms indicated the prepared by, checked by and verified by sections were empty, not signed or identified who completed the destruction of the listed medications. During an observation on 2/9/2026 at 12:08 p.m., in Medication Room Subacute 2, the Director of Pharmacy (DOP) arrived and stated that the DOP does not have keys to the plastic container inside the refrigerator. During an observation on 2/9/2026 at 12:25 p.m., in Medication Room Subacute 2, the Engineering department arrived and stated that Engineering department does not have keys to the container. During an observation and concurrent interview on 2/9/2026 at 12:30 p.m., with Registered Nurse (RN) 4, in Medication Room Subacute 2, there was one (1) medication eKIT stored in the refrigerator and labeled 2, containing CSs without an accountability log for the reconciliation of CS inventory at every shift change for February 2026.^ During a concurrent interview, RN 4 stated that all CSs, including medication eKITs containing CSs should be reconciled at every shift. RN 4 stated the eKIT labeled 2 containing CSs in Medication Room Subacute 2 was not reconciled at every shift in February 2026, and it was important to account for all CSs to ensure accountability and prevent CS diversion.^ During a concurrent record review and interview on 2/9/2026 at 12:40 p.m., with Licensed Vocational Nurse (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(4), LVN 4 reviewed the Floor Narcotic Release log in Medication Cart Subacute Cart 2. LVN 4 stated the Floor Narcotic Release log was the facility's CS accountability record was used for the daily CS reconciliation (review of inventory by 2 people to identify discrepancies) at each shift change and signed with the on-coming and retiring (out-going) nurses, after completing all CS inventory, including refrigerated CSs. LVN 4 stated that LVN 4 (on-coming) and LVN 5 (out-going) could not open the locked plastic clear rectangular container containing CSs inside the refrigerator, and as a result could not verify the count of the CSs inside the refrigerator. LVN 4 stated that LVN 4 and LVN 5 signed the log at 7 a.m. on 2/9/2026 for Medication Cart Subacute Cart 2 without verifying the CS inventory count in the refrigerator. LVN 4 stated that accurate CS reconciliation was important to know the amount of medications available, and if not done properly it can lead to delayed medication treatment and harm residents by not treating their condition requiring hospitalization and leading to possible death. During a review of the Floor Narcotic Release log labeled Cart 2, the log indicated LVN 4 and LVN 5 signed for the completion of the CS reconciliation on 2/9/2026 at 7 a.m. and indicated that the narcotic counts were accurate and that there were no shortages or overages. During an observation on 2/9/2026 at 1 p.m., with RN 4 in Medication Room Subacute 2, the plastic clear rectangular container inside the refrigerator was open. RN 4 stated the keys would get stuck but after several attempts the locks opened. RN 4 acknowledged the following medications were stored inside the container: midazolam (a CS used for seizures [sudden, uncontrolled body movements caused by abnormal electrical activity in the brain leading to loss of muscle control and shaking]) 5mg/ml one (1) ml vial for Resident 11 midazolam 5mg/ml one (1) ml vial for Resident 43 midazolam 5mg/ml one (1) ml vial for Resident 44 midazolam 5mg/ml one (1) ml vial for Resident 49 midazolam 5mg/ml one (1) ml vial for Resident 55 eKIT labeled 24 containing Ativan (a CS used for seizure and anxiety) 2mg/ml one (1) ml vial for facility stock. During a concurrent interview, RN 4 stated it was important to have access to critical medications to provide immediate care to residents. RN 4 stated the facility could not open the locks to the plastic container inside the refrigerator on 2/9/2026 between 11:30 a.m. and 1 p.m. RN 4 stated midazolam and Ativan were used for seizures and need to be administered immediately upon a physician's order. RN 4 stated seizure was considered an emergency and not having timely access to midazolam and Ativan could lead to delay in care and harm Resident 11, 43, 44, 49, 55 and others experiencing seizures, by not controlling the seizure, and leading to hospitalization and/or potential death. During an observation and concurrent interview on 2/9/2026 at 1:57 p.m., with RN 2, in Medication Room Subacute 3 there was one (1) medication eKIT stored in the refrigerator and labeled 24, containing CSs without an accountability log for the reconciliation of CS inventory at every shift change for February 2026. During a concurrent interview, RN 2 stated that all CSs, including medication eKITS containing CSs, should be reconciled at every shift. RN 2 stated the eKIT labeled 24 containing CSs in Medication Room Subacute 3 was not reconciled at every shift in February 2026, and it was important to account for all CSs to ensure accountability and prevent CS diversion. During an interview on 2/9/2026 at 3:45 p.m., with the Director of Nursing (DON,) the DON stated that medication eKITS containing CSs needed to be counted and reconciled at every shift change to ensure accountability and prevent CS diversion. The DON stated the eKITS labeled 2 and 24 containing CSs in Medication Room Subacute 2 and 3 were not reconciled at every shift in February 2026. The DON stated that the facility will immediately implement an accountability log for reconciliation of eKits containing CSs. During the same interview, the DON stated that LVN 4 and LVN 5 failed to notify the DON that the keys do not unlock the clear plastic container inside the refrigerator in Medication [NAME] Subacute 2 that day (2/9/2026) at 7 a.m. The DON stated, as a result LVN 4 and LVN 5 failed to complete a physical inventory and reconciliation of the CSs at shift change but documented that the reconciliation was completed with no discrepancies. The DON stated it was important to complete an actual physical count of all CSs and reconcile at each shift change to prevent CS diversions, and to know the amount of medications available for residents to prevent delay in care and harm such as hospitalizations and death. During the same interview, the DON (continued on next page)		

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reviewed the four (4) Facility Medication Destruction Form records dated 1/2/2026 and 2/9/2026. The DON stated the DON was unable to locate the witness signatures on the logs. The DON stated licensed nurses failed to include the signatures of witnesses when destroying medications. The DON stated it was important to verify and sign these logs with witnesses to prevent medication diversions and accidental exposure to residents. During a review of the Policy and Procedures (P&P,) titled Controlled Medication Storage, last reviewed 1/29/2026, the P&P indicated: Medications included in the Drug Enforcement Administration (DEA) classification as controlled substance are subject to special handling, storage, disposal and record keeping in the facility in accordance with federal, state and other applicable laws and regulations. The DON and the consultant pharmacist shall maintain facility's compliance with federal and state laws and regulations in the handling of controlled medications. At each shift change, a physical inventory of all controlled medications shall be conducted by two licensed nurses and is documented on the controlled substance accountability record. During a review of the Policy and Procedures (P&P,) titled Emergency Pharmacy Services/Emergency Kits, last reviewed 1/29/2026, the P&P indicated: A locked and sealed emergency supply shall be maintained at one or more designated areas Emergency controlled substances are kept in a sealed, portable container. Refrigerated emergency supplies are kept in a sealed, portable container. when an emergency or starter dose of a medication is needed, the nurse shall break the container seal and remove the required medication. During a review of facility's P&P, titled Discontinued Medications - Disposal, last reviewed 1/29/2026, the P&P indicated: b. With the exception of controlled substances, the facility should have at least two licensed nurses prepare the destruction of medications that would be picked up by a licensed reverse distributor like medical waste services. During a review of facility's P&P, titled Destruction of Medications - Non controlled, last reviewed 1/29/2026, the P&P indicated: All non-controlled medication will be properly recorded and prepared before its destruction and placement in a designated collection receptacle. d. Nurses will record all medications for destruction on the medications destruction record form and keep a copy at the facility. The following information will include: 1. Facility Name 2. Date of preparation 3. Name of the patient 4. Rx number 5. Medication name 6. Amount to be disposed 7. Who prepared the medications.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to: Label one (1) open insulin (medication used to regulate blood sugar levels) Lantus (brand name insulin for glargine, a long-acting insulin) Solostar pen (a type of device containing insulin) stored at room temperature for Resident 4, in accordance with manufacturer's requirements in one (1) of three (3) inspected Medication Carts (Medication Cart Subacute 2 Cart 2.) Store eye drop and ear drop medications separately, in one (1) of three (3) inspected Medication Carts (Medication Cart Subacute 2 Cart 2.) These deficient practices increased the risk that Resident 4 could receive medication that had become ineffective or toxic due to inadequate storage, and labeling, experience medication adverse consequences (unwanted, uncomfortable, or dangerous effects that a medication may have) and increase the risk of contamination and receiving medications via the wrong route for residents in the facility, resulting in the negative impact to their health and well-being possibly leading to health complications, hospitalization, or death. Based on observation, interview, and record review the facility failed to: 1.Label one (1) open insulin (medication used to regulate blood sugar levels) Lantus (brand name insulin for glargine, a long-acting insulin) Solostar pen (a type of device containing insulin) stored at room temperature for Resident 4, in accordance with manufacturer's requirements in one (1) of three (3) inspected Medication Carts (Medication Cart Subacute 2 Cart 2.) 2. Store eye drop and ear drop medications separately, in one (1) of three (3) inspected Medication Carts (Medication Cart Subacute 2 Cart 2.) These deficient practices increased the risk that Resident 4 could receive medication that had become ineffective or toxic due to inadequate storage, and labeling, experience medication adverse consequences (unwanted, uncomfortable, or dangerous effects that a medication may have) and increase the risk of contamination and receiving medications via the wrong route for residents in the facility, resulting in the negative impact to their health and well-being possibly leading to health complications, hospitalization, or death. Findings: During an observation on [DATE] at 1:48 p.m., in Medication Cart Subacute 2 Cart 2', and in the presence of Licensed Vocational Nurse (LVN) 3, the following medication was found either stored in a manner contrary to their respective manufacturer's requirements, not labeled with an open date as required by their respective manufacturer's specifications, or stored and labeled contrary to facility policies: -One (1) open and used insulin Lantus for Resident 4 was found stored at room temperature without a date indicating when storage or use at room temperature began. According to the manufacturer's product labeling, open Lantus Solostar insulin pens should be stored at room temperature below 86 degrees Fahrenheit and used or discarded within 28 days of opening pen. Three (3) insulin Lantus Solostar pens, one (1) earwax softener drops, and one (1) lubricant eye drops were stored in the same bin/compartment of the medication cart. During a concurrent interview with LVN 3, LVN 3 stated insulin Lantus Solostar pen for Resident 4 was open, used, stored at room temperature, and not labeled with a date when use at room temperature began. LVN 3 stated insulin pen was considered a multi-dose (having more than one [1] dose) medication. LVN 3 stated according to manufacturer directions the Lantus pen needed to be discarded after 28 days of use, and after that day the insulin loses potency (the strength of medication) and considered expired. LVN 3 stated that LVN 3 was unaware when the insulin Lantus Solostar pen for Resident 4 was opened or stored at room temperature therefore unknown when it would expire. LVN 3 stated administering expired insulin in error will not be effective in keeping the blood sugar stable and can harm Resident 4 by causing high blood sugar levels, leading to shock and coma (a state of deep unconsciousness caused by injury or illness), hospitalization or even death. LVN 3 stated the Lantus Solostar pen needed to be removed from the medication cart and replaced with new ones from pharmacy to ensure expired insulin was not administered in error to Resident 4. (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the same interview, LVN 3 stated that internally administered medications, such as oral tablets and injections, and externally administered medications, such as eye drops and ear drops, should be stored separately in their own sections/bins and not together, to prevent errors in wrong route administration and possible infections/contaminations. LVN 3 acknowledged one (1) medication bin containing three (3) insulin pens, one (1) ear drop and one (1) eye drop. LVN 3 stated the facility failed not to separate and store ear drops separate from eye drop medications. During an interview on [DATE] at 3:45 p.m., with the Director of Nursing (DON,) the DON stated the insulin Lantus Solostar pen for Resident 4 was not labeled with a date when the pen was first opened and used. The DON stated several LVN's failed to label the date the pen was opened and used. The DON stated without knowing when the Lantus Solostar pen was opened it was unknown when it would expire, increasing the risk of administration of expired insulin to Resident 4. The DON stated expired insulins have lost potency and effectiveness and when administered in error were not effective in controlling blood sugar levels leading to hyperglycemia (high blood sugar level) and adverse effects for Resident 4, potentially resulting in hospitalization due to Diabetic Ketoacidosis ([DKA] - a condition that develops when the body doesn't have enough insulin resulting in the buildup of acid in the blood to levels that can be life threatening.) The DON stated the Lantus Solostar pen needed to be replaced with a new one from pharmacy. During the same interview, the DON stated ear drops and eye drops should be stored separately to prevent wrong route administration, infections and contaminations. The DON stated the facility failed to store ear drop and eye drop medication in separate bins/compartments in Medication Cart Subacute 2 Cart 2. During a review of the facility's Policy & Procedures (P&P,) titled Storage of Medications, last reviewed [DATE], the P&P indicated Medications and biologicals shall be stored safely, securely, and properly, following manufacturer's recommendations of those of the supplier. e. Eye medications shall be kept separate from ear medications. ii. Once a refrigerated item such as multi-dose insulin vials are opened, the nurses write down the open date and it must be discarded according to storage table 1 below from the date open. If the refrigerated item is a unit dose item such as pens, then each individual pen may have its own date opened and be discarded according to storage table 1 from the date opened. During a review of the facility's appendix to Storage of Medications P&P titled Storage Table 1, last reviewed [DATE], the table indicated: Lantus (glargine) - Good for 28 days after opening or removing from refrigerator. During a review of manufacturer guideline, titled Highlights of Prescribing Information for Lantus, dated 6/2022, the guide listed the following: Only use your pen for up to 28 days after its first use. Throw away the LANTUS SoloStar pen you are using after 28 days, even if it still has insulin left in it.		

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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 purchased bags of ice, still on their original packaging, were placed on top of the ice made by the ice maker and used for 14 of the 60 residents that eat and drink food prepared by the kitchen. These failures had the potential to result in harmful bacteria growth and cross contamination (a transfer of harmful bacteria from one place to another or one object to another) that could lead to foodborne illness (illness caused by food contaminated with bacteria, viruses, and other toxins) for 14 of the 60 medically compromised residents who received food from the kitchen. Findings: During an initial kitchen tour observation on 2/9/2026 at 7:42 a.m., observed three bags of purchased ice still in their original bags mixed with ice made by the ice maker. During a concurrent observation and interview with the Dietary Manager (DM) on 2/9/2026 at 7:44 a.m., the DM looked into the ice maker and stated there were three bags of ice mixed with the fresh ice made by the ice maker. The DM stated sometimes the ice maker does not work well and they have to purchase separate bags of ice but that the ice should have been removed from the bags to prevent cross contamination. During a review of the policy and procedure (P&P) titled, Ice Machine, last revised on 1/29/2026, the P&P indicated when ice comes in contact with food and beverages shall be from a sanitary source.		

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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 provide reasonable accommodation for resident needs and preferences for two of four sampled residents (Resident 24 and Resident 5) by failing to: Ensure Resident 5's call light (an alerting device that allows a resident to call for help) was within reach. 2. Ensure Resident 24 was provided with a push button call light despite Resident 24 having wrist contractures (a condition where the muscles, tendons, or skin around the wrist tighten, shorten, and scar, causing the joint to become stiff and locked in a bent position) that limited the ability to grasp and activate the call light. This deficient practice had the potential to prevent Resident 5 and Resident 24 from summoning assistance, placing the residents at risk for unmet needs and delayed care. Findings: 1. During a review of Resident 5's admission Record (the front page of the chart that contains a summary of basic information about the resident), the admission Record indicated the facility admitted Resident 5 to the facility on 9/6/2025. During a review of the History and Physical (H&P) report completed on 9/8/2025, the H&P indicated Resident 5 was admitted to the facility with diagnosis that included chronic hypoxemic respiratory failure (a long-term condition where the lungs cannot sufficiently transfer oxygen into the blood), dependence on respirator/ventilator status (unable to breathe independently and requires a machine to help or fully take over a resident's breathing when they cannot do so on their own), and [NAME] Barre syndrome (a condition in which the body's system that protects from infection attack the nerves). The H&P stated Resident 5 was bedbound (confirmed to bed due to illness) state. During a review of Resident 5's Minimum Data Set (MDS &ndash; a resident assessment tool), dated 11/13/2025, the MDS indicated Resident 5 has the ability to express ideas and wants and understands (clear comprehension) others. The MDS indicated Resident 5 was dependent (Helper does all of the effort. Resident does none of the effort to complete the task) with eating, oral hygiene, toileting hygiene, personal hygiene, shower/bathe self, upper and lower body dressing. The MDS indicated that Resident 5 is dependent for roll left and right (ability to roll from laying on back to left and right side and return to laying on back on the bed). During a concurrent observation and interview on 2/9/2026 at 10:10 a.m. with Resident 5, Resident 5 was lying in bed with a touch-activated call light (easy-to-activate communication device alerting staff when resident needs help) on the left side above his head. Resident 5 stated he taps the call light with his head when he needs help. Resident 5 stated he sometimes cannot reach it because of where it is placed. Resident 5 stated that he would verbally call out loud to get staff attention when unable to reach the call light. During a concurrent observation and interview on 2/9/2026 at 10:20 a.m. in Resident 5's room, the call light was observed on the left side above the resident's head, out of Resident 5's reach. LVN 8 stated the touch-activated call light is what Resident 5 uses to let staff know he needs help and should always be within reach of the resident. LVN 8 stated that without the call light, Resident 5 does not have a device to let staff know that he needs help. LVN stated because of this, staff will not know what may be going on with him and/or may miss something. (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/12/2026 at 12:25 p.m. with the Director of Nursing (DON), the DON stated staff are expected to make sure call lights are always within residents' reach and responded to timely. The DON stated you never know what a resident is calling help for, and it may be an emergency, so it is important that residents have a call device within reach to call at all times. During a review of Resident 5's care plan (CP) titled, Risk for falls related to impaired mobility, incontinence of bowel, chronic respiratory failure on trach, muscle spasms, neuropathy, side effects of medications initiated 6/24/2023 the CP indicated an intervention ensure call light is available to resident. During a review of Resident 5's care plan (CP) titled, The resident has an alteration in musculoskeletal status muscle cramping of lower extremities, quadriplegia initiated 01/1/2024, the CP indicated an intervention be sure call light is within reach and respond promptly to all requests for assistance. During a review of Resident 5's care plan (CP) titled, Self-Care Deficit: Totally dependent with bed mobility, bathing, dressing, eating, transfer, toilet use and personal hygiene due to physical and medical condition. Resident uses adaptive call light initiated 01/09/2024, the CP indicated an intervention touch-activated call light, place the call light within easy reach of the patient's bedside. During a review of Resident 5's care plan (CP) titled, Side rail use for safety to prevent falls initiated 7/15/2025, the CP indicated an intervention place call light within reach and respond timely. During a review of the facility's P&P titled, Call Light System last reviewed 1/29/2026, the P&P indicated, It is the policy of this facility to provide each resident with a call system to enable them to request assistance. To provide a mechanism for residents to communicate to staff a need for assistance.Procedure: b. Make sure call cords are placed within the residents' reach at all times. 2. During a review of Resident 24's Patient Registration Form, the Patient Registration Form indicated Resident 24 was admitted to the facility on [DATE]. During a review of Resident 24's H&P, dated 10/13/2025, the H&P indicated Resident 24 was admitted to the facility with diagnoses including traumatic encephalopathy following head injury(permanent brain damage that happens after many head injuries), history of respiratory failure (a condition where there's not enough oxygen or too much carbon dioxide in your body), permanent tracheostomy (a surgically created hole in the neck that leads directly into the windpipe to help a person breathe), seizure disorder (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness). The H&P indicated Resident 24 was awake, responsive, able to verbalize slightly. During a review of Resident 24's MDS dated [DATE], the MDS indicated Resident 24 had moderately impaired cognitive skills (decisions poor; cues/supervision required). The MDS indicated Resident 24 was dependent (helper does all the effort) from staff with all activities of daily living (ADL), such as oral hygiene, toileting hygiene, personal hygiene, shower/bathe self, upper and lower body dressing. The MDS indicated that Resident 24 was dependent with roll left and right (ability to roll from laying on back to left and right side and return to laying on back on the bed). During a concurrent observation and interview on 2/9/2026 at 10:37 a.m. with Resident 24 in Resident 24's room, observed standard push button call light tied to the right upper side rail, resting next to (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 24's right shoulder. Resident 24's wrists and fingers were observed contracted bilaterally. Resident 24 stated he was calling for help by yelling for a nurse. Resident 24 stated he did not know where the call light was located or how to use it. During a concurrent observation and interview on 2/9/2026 at 10:52 a.m. with Licensed Vocational Nurse (LVN) 6, Resident 24 demonstrated his ability to move his arms but could not move his wrists and fingers. LVN 6 stated Resident 24 was able to move left hand fingers slightly. LVN 6 placed the standard push button call light in Resident 24's left hand. Resident 24 was unable to use the standard call light. LVN 6 stated not having a type of a call light that Resident 24 could use may prevent Resident 24 from calling for assistance, resulting in unmet needs and delayed care. During an interview on 2/12/2026 at 3:00 p.m. with Director of Nursing (DON), the DON stated staff were required to provide accommodation or alternative devices when residents were unable to use standard equipment. The DON stated residents being unable to use their call light to request assistance can lead to increased stress, unmet physiological needs, delayed care, and in increased risk for injuries. During a review of facility's Policies and Procedures (P&P), the P&P titled, Call light system dated October 2025, the P&P indicated, It is the policy of this facility to provide each resident with a call system to enable them to request assistance.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow its policy titled, Advance Directives, by not providing assistance with creating an advance directive (a legal document indicating resident preference on end-of-life treatment decisions) for two of four sampled residents (Residents 2 and 27) reviewed under the Advance Directive care area. This deficient practice resulted in Residents 2 and 27 not receiving assistance with creating advance directives, increasing the risk that the residents' wishes regarding their medical care would not be known or honored if they became unable to make or communicate their own decisions Findings: During a review of Resident 2's Patient Registration Form, the Patient Registration Form indicated the facility admitted the resident on 6/11/2022. During a review of Resident 2's History and Physical (H&P), dated 7/11/2025, the H&P indicated Resident 2 had diagnoses including, but not limited to, a history of assault with a spinal cord injury (damage to the bundle of nerves and nerve fibers that transmit signals between the brain and the body resulting in temporary or permanent loss of sensation and motor function) and chronic (long-term) respiratory failure (a condition where the lungs cannot release enough oxygen into the blood) with dependence on a ventilator (a medical device to help support or replace breathing). The H&P further indicated Resident 2 had an impaired mental status, was able to make his needs known, and was able to make some decisions. During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated 12/11/2025, the MDS indicated Resident 2 was cognitively intact (able to think, learn, and remember clearly) and was dependent (helper does all of the effort) for all activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 27's Patient Registration Form, the Patient Registration Form indicated the facility admitted the resident on 9/19/2024. During a review of Resident 27's H&P, dated 5/21/2025, the H&P indicated Resident 27 had diagnoses including, but not limited to, chronic respiratory failure and seizure (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness) disorder. The H&P further indicated Resident 27 was alert and oriented (awake, responsive, and aware). During a review of Resident 27's MDS, dated [DATE], the MDS indicated Resident 27 was cognitively intact and was dependent for all ADLs except eating in which she required moderate assistance (helper does less than half of the effort). During a concurrent interview and record review on 2/12/2026 at 12:02 p.m. with Social Worker (SW) 1, reviewed Resident 2's Advance Health Care Directive Acknowledgment, dated 3/4/2025 and Resident 27's Advance Health Care Directive Acknowledgment, dated 2/12/2025. Resident 2's and Resident 27's Advance Health Care Directive Acknowledgements both indicated that the residents did not have an advance directive, but both residents' Advance Health Care Directive Acknowledgment indicated: However, I would like to discuss Advance Directives further: Nursing to refer for follow up. SW 1 stated there was no documentation of having met with either Resident 2 or 27 to follow up about an advance directive and neither have an advance directive on file now. SW 1 stated the usual process is for nursing to ask the resident if they have an advance directive when they are admitted , and if they do not, but want more information to refer them to social services so that a social services staff can provide education regarding making an advance directive, give them a blank one, and can contact the ombudsman (an advocate for residents of nursing homes, board and care centers, and assisted living facilities) to help complete the advance directive. SW 1 stated it is important to meet with the resident and give them education regarding creating an advance directive, as this is their right and ensures staff are aware of their wishes and able to act accordingly if the resident becomes unable to make or communicate their own decisions. During a review of the facility's policy and procedure (P&P) titled, Advance Directives, last reviewed 1/29/2026, the P&P indicated if the resident indicates that he or she has not established an advance directive, the facility will offer assistance to establish (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	one. The P&P indicated the resident will be given the option to accept or decline the assistance. The P&P indicated nursing staff will document in the medical record the offer to assist and the resident's decision to accept or decline the assistance.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide care in accordance with professional standards for one (1) of one (1) sampled residents (Resident 26) investigated for gastrostomy tube ([G-tube] - a tube inserted through the belly that delivers nutrition and medications directly to the stomach) care by failing to flush the tube with the prescribed volume of water. This deficient practice increased the risk that Residents 26 could experience adverse effects (unwanted, unintended result) from lower volume of water, possibly leading to clogging of the G-tube and requiring procedures for declogging (removing a blockage) or replacement of the tube. Findings: During an observation on 2/9/2026 at 9:20 a.m. in Medication Cart 4, licensed vocational nurse (LVN) 7 was observed flushing Resident 26's G-tube with 25 milliliter ([ml] - a unit of measure of volume) followed by administering amiodarone (a medication used for middle cerebral artery (mca) occlusion (a blood clot blocking the largest brain artery, not allowing blood flow to major brain areas,) losartan (a medication used for high blood pressure,) polyethylene glycol 3350 (a medication used for constipation,) amlodipine (a medication used for high blood pressure,) docusate (a medication used for constipation,) ferrous sulfate (a medication used for anemia,) metoprolol (a medication used for high blood pressure,) magnesium oxide (a medication used for constipation,) via G-tube with 5 ml water flushes in between each medication, and flushing the G-tube with an additional 25 ml water after the last medication. During an interview on 2/9/2026 at 10:30 a.m., with LVN 7, LVN 7 stated flushing G-tube with water before and after medication administration was a standard of practice to prevent clogging the tube and ensuring medication has cleared the tube. LVN 7 stated the flushes usually range between 20 and 30 ml. LVN 7 stated LVN 7 decided to flush with 25 ml since it falls in between 20 and 30 ml. LVN 7 acknowledged the physician order for Resident 26 indicated to flush with 30 ml water before and after medication administration through the G-tube. LVN 7 stated LVN 7 failed to flush with the prescribed amount increasing the risk of clogging Resident 26's G-tube, requiring declogging or potential tube preplacement. During an interview on 2/9/2026 at 3:45 p.m., with the Director of Nursing (DON,) the DON stated flushing G-tube with water before and after medication administration and in between each medication was a standard of practice. The DON stated Resident 26's order indicated to flush before and after medication administration through the G-tube with 30 ml water. The DON stated LVN 7 failed to flush Resident 26's G-tube with 30 ml water that day (2/9/2026) during medication administration increasing the risk of clogging Resident 26's G-tube, requiring declogging or potential tube preplacement. During a review of Resident 26's History and Physical ([H&P] - a document containing resident health history, diagnosis and treatment plan,) dated 4/30/2025, the H&P indicated the facility originally admitted the resident to the facility on 3/24/2025 and re-admitted on [DATE] with diagnoses including respiratory distress, mca occlusion, and dysphagia (difficulty swallowing.) During a review of Resident 26's Order Summary Report, dated 2/9/2026, the report indicated Resident 26 was prescribed to Flush tube with 30 ml of water before and after medication administration pass, starting 5/3/2025. During a review of Resident 26's Medication Administration Record ([MAR] - a record of medications administered to residents), for February 2026, the MAR indicated Resident 26 was prescribed Flush tube with 30 ml of water before and after medication administration pass, daytime and nighttime. During a review of Resident 26's Care Plan (a person-centered guide identifying a resident's health and daily needs,) dated 5/1/2025, the care plan indicated: The resident will remain free of side effects or complications related to tube feeding. The resident is dependent with tube feeding and water flushes. See MD orders for current feeding orders. During a review of the facility's Policy & Procedures (P&P,) Medication Administration, last reviewed 1/29/2026, indicated: 10. Flush the tube with approximately 30 ml of water using a catheter tipped syringe. 15. Rinse medication cup and administer rinsing to assure complete dose 16. Flush tube with a minimum of 30 ml of water. During a review of the American Society for Parenteral (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and Enteral Nutrition (ASPEN) standards, titled ASPEN Safe Practices for Enteral Nutrition Therapy, dated January 2017, the guideline indicated: Feeding tubes (known as [NAME]) are prone to clogging for a variety of reasons. The risk of clogging may result from .insufficient water flushes. Develop protocols that call for proper flushing before and after medication administration .Develop protocols for proper administration of medications through an EAD, as well as appropriate water flushes and EAD reclogging procedures.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide preventative care for one of one sampled resident (Resident 64) by not applying sequential compression device (SCD-inflatable sleeves wrapped around the legs that automatically inflate and deflate to mimic muscle movement, increasing blood flow and preventing deep vein thrombosis [DVT-a condition where a blood clot [clump of blood cells in blood stream] forms in a deep vein]) at all times to prevent DVT as ordered by the physician. This deficient practice had the potential to increase the risk of developing blood clots, causing pain, poor blood circulation and serious harm to Resident 64's health. Findings: During a review of Resident 64's Patient Registration Form, the Patient Registration Form indicated that Resident 64 was originally admitted to the facility on [DATE], then readmitted to the facility on [DATE]. During a review of the History and Physical (H&P) dated 4/2/2025, the H&P indicated Resident 55 was admitted to the facility with diagnoses including chronic respiratory failure (a condition where there's not enough oxygen or too much carbon dioxide in your body), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), history of deep venous thrombosis ([DVT] - a serious medical condition where a blood clot forms in a deep vein), history of pulmonary embolism (a sudden, often life-threatening blockage in one or more arteries in the lungs). During a review of Resident 64's Minimum Data Set ([MDS] - a resident assessment tool) dated 12/24/2025, the MDS indicated Resident 64 was cognitively intact (able to make clear decisions). The MDS indicated that Resident 64 was dependent (helper does all the effort) from staff with toileting hygiene, shower, upper and lower body dressing, putting on/taking off footwear and personal hygiene. The MDS indicated that Resident 64 was dependent with sit to stand (the ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed) and chair/bed-to-chair transfer (he ability to transfer to and from a bed to a chair (or wheelchair). During an observation on 2/9/2026, at 9:30 a.m., in Resident 64's room, Resident 64 was lying down in bed with two side rails up. Observed SCD hanging over the footboard of Resident 64's bed. The SCD was not connected to Resident 64 and was off. During a review of Resident 64's Order Summary Report dated 1/29/2026, the Order Summary Report indicated the physician order for SCD on for DVT prophylaxis (prevention) at all times. During a concurrent observation and interview on 2/10/2026 at 2:45 p.m. with Registered Nurse (RN) 4, in Resident 64's room, the SCD was observed on Resident 64's bed hanging on the footboard. RN 4 stated the SCD was disconnected from Resident 64 and was turned off. RN 4 stated Resident 64 had a history of DVT. RN 4 emphasized the importance of using SCD for Resident 64 at all times. RN 4 stated not using SCD put Resident 64 at great risk for developing blood clots and lead to serious health problems. During a concurrent interview and record review on 2/10/2026 at 2:50 p.m. with RN 4, Resident 64's Care Plan Report did not indicate documentation for SCD use. RN 4 stated not developing a care plan for SCD use could lead to staff not using the SCD consistently, increasing the risk for Resident 64 developing blood clots. During an interview on 2/12/2026 at 3:00 p.m. with Director of Nursing (DON), the DON stated not applying SCD as ordered by physician for Resident 64 with a history of DVT can increase the risk of Resident 64 developing blood clots, which could lead to pulmonary embolism and other serious health problems. During a review of facility's Policies and Procedures (P&P), the P&P titled, Sequential Compression Device (SCD) Application and Management, dated December 2025, the P&P indicated, Nurses will remove sleeves every shift to look at skin and when bathing. Otherwise, SCD device and sleeves should remain in place.		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide appropriate services, equipment and assistance to one of three residents (Resident 8) reviewed under the care area of Position/Mobility, to maintain or improve mobility by not applying ankle-foot orthosis ([AFO] - a brace made of plastic or metal to support the lower leg and foot) in accordance with the facility's splinting protocol (rules for temporary, rigid immobilization of a joint to prevent further damage, reduce pain, and protect soft tissue) and physician's order. This deficient practice had the potential to increase the risk for decreased Range of Motion ([ROM] - the full distance and direction a joint can move comfortably, measuring how far you can bend, straighten, or rotate it), discomfort and worsening of Resident 8's contractures (a permanent tightening or shortening of muscles, tendons, skin, or other tissues that causes joints to become stiff, deformed, and limited in movement). Findings: During a review of Resident 8's Patient Registration Form, the Patient Registration Form indicated that Resident 8 was originally admitted to the facility on [DATE], then readmitted to the facility on [DATE]. During a review of the History and Physical (H&P) dated 12/19/2025, the H&P indicated Resident 8 was admitted with diagnoses including cardiopulmonary arrest (a medical emergency where the heart suddenly stops beating, stopping blood flow to the brain and body), respiratory failure (a condition where there's not enough oxygen or too much carbon dioxide in your body), encephalopathy (damage or disease that affects the brain), hypertension (high blood pressure), diabetes mellitus ([DM]-a disorder characterized by difficulty in blood sugar control and poor wound healing). Resident 8 was comatose (a state of deep, prolonged unconsciousness where a person cannot be awakened, fails to respond to light, sound, or pain, and does not move voluntarily) and totally unresponsive to verbal and painful stimuli. During a review of Resident 8's Minimum Data Set ([MDS] - a resident assessment tool) dated 12/24/2025, the MDS indicated Resident 8 was comatose. Resident 8 was dependent (helper does all the effort) from staff with all activities of daily living (ADL), such as oral hygiene, toileting hygiene, personal hygiene, shower/bathe self, upper and lower body dressing. The MDS indicated that Resident 8 was dependent with rolling left and right (ability to roll from laying on back to left and right side and return to lying back on the bed). During an observation on 2/9/2026, at 9:26 a.m., in Resident 8's room, Resident 8 observed having bilateral (both sides) wrist and ankle contractures with no splints applied. During a concurrent interview and record review on 2/10/2026 at 10:50 a.m. with Registered Nurse (RN) 3, RN 3 reviewed Resident 8's electronic and paper medical records. RN 3 stated Order Summary Report dated 2/1/2026, indicated the physician ordered to continue Restorative Nursing Assistant (RNA)/Nursing program for application of bilateral AFOs per splinting protocol. RN 3 stated that per facility's splinting protocol, splints must be applied per physician's order, removed every 2 hours by RNA to check for skin integrity and blood circulation. During a concurrent observation and interview on 2/10/2026 at 10:55 a.m. with RN 3 in Resident 8's room, Resident 8 was observed not having splints applied to his ankles. RN 3 stated that not having the splints applied to Resident 8's feet and ankles as ordered by the physician could place the resident at risk for worsening contractures and reduce mobility. During an interview on 2/12/2026 at 3:00 p.m. with Director of Nursing (DON), the DON stated not applying splints as ordered by the physician was not acceptable practice. The DON stated not applying splinting can lead to worsening of contractures, increased muscle spasms and further loss of function. During a review of facility's Policies and Procedures (P&P), the P&P titled, Splint Application & Use, dated December 2025, the P&P indicated, Splints are to be worn according to the schedule determined by written order of the physician.		

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents who were incontinent (lacks voluntary control over urination) of bladder received appropriate treatment and services to prevent urinary tract infections (UTI- an infection in the bladder/urinary tract) for two of three sampled residents (Resident 1 and Resident 8) by failing to keep Resident 1 and Resident 8's urinary indwelling catheter (a tube inserted into the bladder to drain or collect urine) in a manner that prevents urine backflow. This deficient practice had the increased potential for Resident 1 and Resident 8 to develop catheter associated urinary tract infection (CAUTI - UTI developed in a resident with an indwelling catheter). Findings: a. During a review of Resident 1's admission Record (the front page of the chart that contains a summary of basic information about the resident), the admission Record indicated the facility admitted Resident 1 to the facility on [DATE]. During a review of the History and Physical (H&P) report completed on 12/1/2025, the H&P indicated Resident 1 was admitted to the facility with diagnosis that included acute hypoxemic respiratory failure (a medical emergency where the lungs suddenly cannot transfer enough oxygen into the bloodstream to preserve normal organ function), diabetes mellitus (a chronic condition that affects the way the body processes blood sugar), and history of urinary tract infection (UTI &ndash; an infection of the urinary system, which includes the kidneys, ureters, bladder and urethra). During a review of Resident 1's Minimum Data Set (MDS &ndash; a resident assessment tool), dated 12/12/2025, the MDS indicated Resident 1 rarely/never able to make self-understood and rarely/never able to understand others. The MDS indicated Resident 1's cognitive skills for decision making are severely impaired (never/rarely made decisions). The MDS indicated Resident 1 was dependent (helper does all of the effort) with oral hygiene, toileting hygiene, personal hygiene, shower/bathe self, upper and lower body dressing. During a review of Resident 1's Order Summary Report, dated 2/11/2026, the Order Summary Report indicated a physician's order on 11/29/2025 for Foley catheter size 16x10 every shift for wound management. During a concurrent observation and interview on 2/10/2026 at 4:10 p.m. with Licensed Vocational Nurse (LVN) 1, Resident 1 was lying down in bed with a urinary catheter bag hanging on the left side of the resident's bed frame with amber yellow liquid. Observed a dependent loop (is when a tubing dips downward and traps fluid, which can block proper drainage) with urine collecting in the catheter tubing close to the resident's urethral meatus (external opening at the end of the penis in male or above the vaginal opening in females where urine exits the body). Resident 1 had an empty leg strap (band that secures a catheter or drainage bag to the thigh or calf to ensure the bag stays in the correct position for drainage) on his left thigh without the catheter attached. LVN 1 stated the leg strap should be holding the catheter to prevent dislodgement and maintain the position of the catheter where the urine flows downward from when it empties from the resident's bladder. LVN 1 stated improper placement of urine catheter may cause urine to flow back to the resident and cause a UTI. LVN 1 also stated that there is a risk of it becoming clogged if urine cannot flow freely. (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/12/2026 at 12:25 p.m. with the Director of Nursing (DON), the DON stated that urine catheter should be secured with a leg strap with the urinary catheter bag hanging below the level of the bladder. The DON emphasized that the catheter tubes should not be kinked or contain any dependent loops, as this may cause urine to flow back and potentially result in a urinary tract infection (UTI). During a review of Resident 1's care plan (CP) titled, The resident has indwelling urinary catheter indicated for wound management. At risk for urinary tract infection. At risk for urine backflow due to resident moving catheter, the CP indicated to apply leg strap as indicated and maintain proper alignment of indwelling catheter free of kinks. b. During a review of Resident 8's Patient Registration Form, the Patient Registration Form indicated that Resident 8 was originally admitted to the facility on [DATE], and readmitted to the facility on [DATE]. During a review Resident 8's H&P dated 12/19/2025, the H&P indicated Resident 8 was admitted with diagnoses including cardiopulmonary arrest (a medical emergency where the heart suddenly stops beating, stopping blood flow to the brain and body), respiratory failure (a condition where there's not enough oxygen or too much carbon dioxide in your body), encephalopathy (damage or disease that affects the brain), hypertension (high blood pressure), and diabetes mellitus. Resident 8 was comatose (a state of deep, prolonged unconsciousness where a person cannot be awakened, fails to respond to light, sound, or pain, and does not move voluntarily) and totally unresponsive to verbal and painful stimuli. During a review of Resident 8's MDS dated [DATE], the MDS indicated Resident 8 was comatose. Resident 8 was dependent from staff with all activities of daily living (ADL), such as oral hygiene, toileting hygiene, personal hygiene, shower/bathe self, upper and lower body dressing. The MDS indicated that Resident 8 was dependent with rolling left and right. During a concurrent observation and interview on 2/10/2026 at 10:55 a.m. with RN 3 in Resident 8's room, Resident 8 was observed to have suprapubic indwelling urinary catheter (urinary catheter inserted through the area just above the pubic bone) securely attached to Resident 8's left thigh then to the drainage tube (the tube connecting a urine catheter to a drainage bag) laid over a positioning wedge (a firm foam triangle used to support, stabilize, or elevate specific body parts while a person is in bed). RN 3 stated the tubing was above the level of Resident 8's bladder, and urine was visibly backing up toward the resident's body. RN 3 further stated this positioning of the tubing could increase the risk for UTIs and CAUTIs. During an interview on 2/12/2026 at 3:00 p.m. with the DON, the DON stated it was not acceptable practice for catheter tubing to be positioned above the level of residents' bladder level. The DON explained that the tubing must remain below bladder level and the drainage bag should not touch the floor. The DON further stated that positioning the tubing above the bladder can interfere with urine flow, potentially causing obstruction and increasing the risk of CAUTIs. During a review of the facility's P&P titled, Infection Control Plan 2025 last reviewed 1/29/2026, the P&P indicated, Pacifica Hospital of the Valley to maintain a comprehensive and effective program of surveillance, prevention, and control of infection. The organization will employ a coordinated process to reduce the risks of endemic and epidemic, or healthcare-associated infection(s) in patients and healthcare workers. Infection Prevention will be comprehensive and address issue(s) identified as (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	epidemiologically significant and demographically sound. These issues include but are not limited to the following: Device-related infections, especially those associated with intravascular devices, urinary catheters, and ventilators.Risk Mitigation: Adherence to CDC guidelines and toolkits: Catheter-associated urinary tracts infections (CAUTI).		

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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** Based on observation, interview and record review, the facility failed to maintain accurate clinical records in accordance with accepted professional standards and practices for one of four sampled residents (Resident 13) when Respiratory Therapist 2 (RT 2) documented on the Medication Administration Record (MAR - a daily documentation record used by licensed staff to document medications and treatments given to a resident) that Resident 13's bubble humidifier (a medical device that includes a plastic bottle partially filled with distilled water to add moisture to supplemental oxygen given to residents) was changed when the bubble humidifier had not changed. This deficient practice resulted in inaccurate documentation in Resident 13's medical record. Findings: During a review of Resident 13's admission Record (the front page of the chart that contains a summary of basic information about the resident), the admission Record indicated the facility admitted Resident 13 to the facility on [DATE]. During a review of the History and Physical (H&P) Note completed on 9/21/2023, the H&P indicated Resident 13 was admitted to the facility with diagnosis that included chronic hypoxemic respiratory failure (a long-term condition where the lungs cannot sufficiently transfer oxygen into the blood), cerebral vascular accident (CVA -stroke, loss of blood flow to a part of the brain), and post percutaneous endoscopic gastrostomy (PEG - medical device inserted into the stomach to provide essential nutrition, fluids, and medication or require long term feeding). The H&P indicated Resident 13 is unable to make decisions. During a review of Resident 13's Minimum Data Set (MDS - a resident assessment tool), dated 12/19/2025, the MDS indicated Resident 13 rarely/never able to make self-understood and rarely/never able to understand others. The MDS indicated Resident 13 was dependent (helper does all of the effort) with oral hygiene, toileting hygiene, personal hygiene, shower/bathe self, upper and lower body dressing. During an observation on 2/9/2026 at 8:33 a.m. at Resident 13's bedside, a bubble humidifier dated 2/4 was observed connected to Resident 13's oxygen tubing. During an interview on 2/9/2026 at 11:13 a.m. with Respiratory Therapist (RT), RT 1 stated the date on the bubble humidifier indicates when it was last changed. RT 1 stated that Resident 13's bubble humidifier was dated 2/4, indicating that it was last changed on 2/4/2026 and had not been changed on 2/6/2026 as scheduled per physician orders. During a review of Resident 13's Order Summary Report, dated 2/11/2026, the Order Summary Report indicated a physician's order on 12/18/2023 to change the bubble humidifier in the morning every Monday, Wednesday, and Friday. During a review of Resident 13's MAR dated February 2026, the MAR indicated that on 2/6/2026 for the 9am administration time, there were staff initials in the box for the order to change bubble humidifier in the morning of every Monday, Wednesday, and Friday, indicating the task had been completed. During an interview on 2/12/2026 at 11:19 a.m. with RT 2, RT 2 stated he documented on Resident 13's MAR on 2/6/2026 at 9am that he changed the bubble humidifier before he went to Resident 13's bedside to perform the task. RT 2 explained that when he went to Resident 13's bedside, Resident 13 was occupied and receiving care from another staff. RT 2 stated he did not change the bubble humidifier and meant to return later but forgot. RT 2 stated, It slipped my mind. RT 2 stated that he should not have documented the bubble humidifier was changed as accuracy in MAR documentation is important because it informs the healthcare team of the completion status of the physician's orders. RT 2 stated that the inaccurate documentation on Resident 13's MAR implied the bubble nebulizer was changed, and it did not require another RT to perform the task, which resulted in Resident 13's bubble nebulizer not being changed at all on 2/6/2026. During an interview on 2/12/2026 at 3:35pm with the Director of Nursing (DON), the DON stated that documentation should be done only after the intervention has been performed. The DON stated that the task must first be completed, then documented. During a review of the facility's P&P titled, Oxygen Therapy last reviewed 1/29/2026, the P&P indicated, To deliver supplemental oxygen to aid the relief of tissue (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hypoxia or hypoxemia.Equipment:.Bubble humidifier or aerosol humidifier, if trach resident.Procedure: 6. Connect humidifier to outlet of flowmeter. Label with date opened.Documentation: Date and time oxygen therapy is in use. During a review of the facility's P&P titled, Medication Administration: last reviewed 1/29/2026, the P&P indicated, Ordering medications - Medications and treatments shall be administered only upon the written order of a person lawfully authorized to prescribe for and treat human illnesses.Administration - All medications and treatments shall be administered by licensed health care professionals as followed by state law.These policies and procedures are established to assure the most complete and accurate implementation of physicians' medication orders and to optimize drug therapy for each resident by providing for administration of drugs in an accurate, safe, timely and sanitary manner. General Policy a. All entries in the health record involving medications shall be made by licensed personnel.d. Documentation of medication doses administered shall be charted as soon as possible after administration to any individual resident.		

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement its protocol for Antibiotic Stewardship Program (a coordinated program that promotes the appropriate use of drugs used to treat infections, including antibiotics [medications that fight infections caused by bacteria]) for one of one sampled resident (Resident 8) by not completing an Antibiotic Time-Out (a scheduled check-up, treatment is paused to re-evaluate if the medication is still necessary, effective, or needs adjustment) between 48 to 96 hours of therapy initiation as indicated in facility's policies and procedures (P&P). This deficient practice had the potential to result in inappropriate or prolonged antibiotic use, increased risk of side effects (unwanted effects of medications), and antibiotic resistance (occurs when bacteria evolve to survive drugs designed to kill them, making infections difficult or impossible to treat). Findings: During a review of Resident 8's Patient Registration Form, the Patient Registration Form indicated that Resident 8 was originally admitted to the facility on [DATE], then readmitted to the facility on [DATE]. During a review of the History and Physical (H&P) dated 12/19/2025, the H&P indicated Resident 8 was admitted with diagnoses including cardiopulmonary arrest (a medical emergency where the heart suddenly stops beating, stopping blood flow to the brain and body), respiratory failure (a condition where there's not enough oxygen or too much carbon dioxide in your body), encephalopathy (damage or disease that affects the brain), hypertension (high blood pressure), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). Resident 8 was comatose (a state of deep, prolonged unconsciousness where a person cannot be awakened, fails to respond to light, sound, or pain, and does not move voluntarily) and totally unresponsive to verbal and painful stimuli. During a review of Resident 8's Minimum Data Set ([MDS] - a resident assessment tool) dated 12/24/2025, the MDS indicated Resident 8 was comatose. Resident 8 was dependent (helper does all the effort) from staff with all activities of daily living (ADL), such as oral hygiene, toileting hygiene, personal hygiene, shower/bathe self, upper and lower body dressing. The MDS indicated that Resident 8 was dependent with rolling left and right (ability to roll from laying on back to left and right side and return to lying back on the bed). During a concurrent interview and record review on 2/11/2026 at 11:15 a.m. with the Infection Preventionist Nurse (IPN), the Resident 8's Order Summary Report dated 1/21/2026 indicated Physician order for Zosyn (an antibiotic medicine used to treat serous bacterial infections) solution 3-0.375 Gm/50 ml (unit of measurement) to be used 1 dose intravenously (through veins) every 8 hours for elevated white blood cells ([WBC] - a blood cell that helps attack infection or injury in the body) for 7 days. The IPN stated that it was the facility's policy to conduct antibiotic time-off within 48 to 72 hours of antibiotic treatment initiation to assess if the treatment had been effective. The IPN reviewed Resident 8's electronic and paper medical records. The IPN stated there was no documentation of antibiotic time-off assessment. The IPN stated this could lead to unnecessary use of antibiotics, increased risk of side effects and antibiotic resistance. During an interview on 2/12/2026 at 3:00 p.m. with Director of Nursing (DON), the DON stated it was the facility's policy to perform and document an antibiotic time-out for Residents who are currently on antibiotics. Time out expected to be completed within two to four days of starting the antibiotic treatment. The DON stated if the time-out is not done or documented, staff may not know treatments efficiency, which can lead to inappropriate antibiotic use, increased risk of antibiotic resistance, and possible adverse reactions. During a review of the facility's policy and procedure (P&P) titled, Antibiotic Stewardship Program, reviewed/revised in January 2026, the P&P indicated the facility will utilize a process for completion of an Antibiotic Time-Out between 48 and 96 hours of therapy initiation.		

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interview and record review, the facility failed to ensure one of one sampled Certified Nursing Assistant (CNA) reviewed for sufficient and competent nurse staffing was provided the required annual in-service training for dementia (a condition characterized by decline in mental ability such as memory, reasoning and communication) management. The deficient practice had the potential to negatively affect the quality of care received by residents with dementia. Findings: During a concurrent interview and record review on 2/12/2026 at 1:50 p.m. with the Human Resources Supervisor (HRS), Restorative Nursing Assistant (RNA- a CNA who has received additional training in restorative care) 2's employee file was reviewed. The HRS stated there was no record of RNA 2 having received dementia training in the last 12 months. During an interview on 2/12/2026 at 3:03 p.m. with the Director of Staff Development (DSD), the DSD stated he is responsible for ensuring required trainings are completed. The DSD stated that dementia training was not provided to RNAs in the last 12 months and will ensure dementia management training is provided annually moving forward. The DSD stated dementia training enhances staff knowledge about dementia and how to care for residents with this condition. The DSD stated that without proper dementia training, staff may misinterpret residents' behaviors and fail to implement appropriate interventions. The DSD stated that dementia management training equips staff with the necessary knowledge to provide effective care tailored to the specific needs of residents with dementia. During a review of the facility's P&P titled, Sub-Acute Staff Training last reviewed 1/29/2026, the P&P indicated, All Sub-acute staff must participate in initial orientation and annual in-service training. All staff are required to participate in regular in-service education. The primary objective of the in-service training is to ensure that staff are able to interact in a manner that enhance the resident's quality of life and quality of care and can demonstrate competency in the topic areas of the training. Required training topics include the following: (3) dementia management and resident abuse prevention. Training requirements are met prior to staff providing services to residents, annually, and as necessary based on the facility assessment. Completed training is documented by the staff development coordinator, or his or her designee and includes: the date and time of the training; the topic of the training; a summary of the competency assessment; and the hours of training completed		