STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555716	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Valley Subacute and Nursing Center	6740 Wilbur Ave Opco, LLC Reseda, CA 91335

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42275 Based on interview and record review, the facility failed to develop a comprehensive person-centered care plan (a plan for an individual's specific health needs and desired health outcomes) to address and accommodate the resident's food preferences for milk and more fruits each meal for one of three sampled residents (Resident 1). These deficient practices had the potential to result in a delay in or lack of delivery of care and services. Findings: A review of Resident 1's Admission Record indicated the facility originally admitted Resident 1 on 4/25/2022 and readmitted on [DATE] with diagnoses including respiratory failure (a serious condition that makes it difficult to breathe on your own) with hypoxia (low levels of oxygen in your body tissues), tracheostomy (a surgically created hole in your windpipe that provides an alternative airway for breathing), dependence on respirator (also called ventilator, a machine used to help a resident breathe), diabetes mellitus (a condition that happens when your blood sugar is too high), and bipolar disorder (is a serious mental illness that causes unusual shifts in mood, ranging from extreme highs to lows). A review of Resident 1's Minimum Data Set (MDS - a standardized assessment and care planning tool) dated 3/6/2023 indicated Resident 1's cognition (ability to think and make decisions) was intact. The MDS further indicated that Resident 1 required limited assistance from staff with eating and extensive assistance from staff with bed mobility, transfer, dressing, personal hygiene, and toilet use. A review of Resident 1's Nutritional Care Assessment (NCA) dated 3/8/2023 indicated that Resident 1's recent body weight was 369 pounds (lb. - a unit of measure), had five (5) percent (%) weight loss in 90 days and could be due to inadequate oral intake. Resident 1's NCS further indicated that Resident 1 requested lighter food for him to eat easier and for more fruits and milk with every meal. During a concurrent interview and record review with Registered Dietician 1 (RD 1) on 4/24/2024 at 12:16 p. m., RD 1 reviewed Resident 1's NCA dated 3/8/2023 and stated that RD 1 recommended to add milk and fruits each meal per Resident 1's request and food preferences. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review with Licensed Vocational Nurse 1 (LVN 1) on 4/24/2024 at 1:00 p.m., LVN 1 reviewed Resident 1's NCA dated 3/8/2023 and Resident 1's care plans. LVN 1 stated, for any changes of diet including resident's food preferences, the facility should inform the resident's physician and update the resident's care plan. LVN 1 stated she reviewed all the care plans for Resident 1 but was unable to locate a care plan regarding Resident 1's food preferences for milk and more fruits each meal. During an interview with Minimum Data Set Nurse (MDSN - collects and assesses information for the health and well-being of residents) 1 on 4/25/2024 at 11:05 a.m., MDSN 1 stated, reviewed Resident 1's care plans related to the nutritional needs, but the facility did not develop and implement a comprehensive care plan for Resident 1's food preferences for more milk and fruits each meal. A review of the facility's policy and procedure (P&P) titled, Resident Food Preferences, last reviewed in July/2023, indicated, Modifications to diet will only be ordered with the resident's or representative's consent Nursing staff will document the resident's food and eating preferences in the care plan. A review of the P&P titled, Care Plan Comprehensive, last reviewed in July/2023, indicated, The facility's Interdisciplinary Team, in coordination with the resident and/or his/her family or representative, must develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet a resident's medical, physical, and mental and psychosocial needs that are identified in the comprehensive assessment Each resident ' s comprehensive care plan is designed to Build on the resident's individualized needs, strengths, preferences.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42275 Based on interview and record review, the facility failed to accommodate food preferences for milk and more fruits each meal for one of three sampled residents (Resident 1). This deficient practice had the potential to result in decreased meal intake and can lead to weight loss. Findings: A review of Resident 1 ' s Admission Record indicated the facility originally admitted Resident 1 on 4/25/2022 and readmitted on [DATE] with diagnoses including respiratory failure (a serious condition that makes it difficult to breathe on your own) with hypoxia (low levels of oxygen in your body tissues), tracheostomy (a surgically created hole in your windpipe that provides an alternative airway for breathing), dependence on respirator (also called ventilator, a machine used to help a resident breathe), diabetes mellitus (a condition that happens when your blood sugar is too high), and bipolar disorder (is a serious mental illness that causes unusual shifts in mood, ranging from extreme highs to lows). A review of Resident 1 ' s Minimum Data Set (MDS - a standardized assessment and care planning tool) dated 3/6/2023 indicated Resident 1 ' s cognition (ability to think and make decisions) was intact. The MDS further indicated that Resident 1 required limited assistance from staff with eating and extensive assistance from staff with bed mobility, transfer, dressing, personal hygiene, and toilet use. A review of Resident 1 ' s Nutritional Care Assessment (NCA) dated 3/8/2023 indicated that Resident 1 ' s recent body weight was 369 pounds (lb. - a unit of measure), had five (5) percent (%) weight loss in 90 days and could be due to inadequate oral intake. Resident 1 ' s NCS further indicated that Resident 1 requested lighter food for him to eat easier and for more fruits and milk with every meal. During a concurrent interview and record review with Registered Dietician 1 (RD 1) on 4/24/2024 at 12:16 p. m., RD 1 reviewed Resident 1 ' s NCA dated 3/8/2023 and stated that RD 1 recommended to add milk and fruits each meal per Resident 1 ' s request and food preferences. When RD 1 was asked how the facility accommodated the resident ' s food preferences, RD 1 stated a diet communication slip must be completed and handed off to the dietary department. RD 1 stated a copy of the diet communication slip must be maintained in Resident 1 ' s records. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review with Licensed Vocational Nurse 1 (LVN 1) on 4/24/2024 at 12:40 p.m., LVN 1 reviewed Resident 1 ' s NCA dated 3/8/2023 and Physician orders dated 3/1/2024, LVN 1 further reviewed Resident 1 ' s four closed records; admitted on [DATE] and discharged on [DATE], readmitted on [DATE] and discharged on [DATE], readmitted on [DATE] and discharged on [DATE], and readmitted on [DATE] and discharged on [DATE]. LVN 1 stated that she reviewed Resident 1 ' s physician diet orders and communication slips between the dietary department and the nursing department but was unable to locate documented evidence that indicated Resident 1 ' s food preference for milk and more fruits each meal was accommodated. During an interview with the Dietary Supervisor (DS) on 4/24/2024 at 3:20 p.m., DS stated that she was unable to locate any diet communication slips related to Resident 1 ' s food preference for milk and more fruits each meal. The DS stated the facility was unable to follow and provide RD ' s recommendations on 3/8/2023. A review of the facility ' s policy and procedure (P&P) titled, Resident Food Preferences, last reviewed in July/2023, indicated, Individual food preferences will be assessed upon admission and communicated to the interdisciplinary team (IDT - team members from different disciplines working collaboratively, with a common purpose, to set goals, make decisions and share resources and responsibilities). Modifications to diet will only be ordered with the resident ' s or representative ' s consent Nursing staff will document the resident ' s food and eating preferences in the care plan.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 43636 Based on interview and record review, the facility failed to ensure Nurse Practitioner 1 (NP 1) did not willfully falsify (knowingly make a false entry into a resident ' s medical record) progress notes for one of three sampled residents (Resident 1) on 1/22/2023, 2/6/2023, and 2/21/2023. This willful material falsification (WMF - when a staff purposefully documents false information in a medical record) resulted in the clinical record of Resident 1 fraudulently reflecting the care provided. Findings: A record review of Resident 1 ' s Admission Record indicated the facility originally admitted Resident 1 on 4/25/2022 and readmitted Resident 1 on 2/28/2023 with diagnoses including respiratory failure (a serious condition that makes it difficult to breathe) with hypoxia (low levels of oxygen in your body tissues), tracheostomy(a surgically created hole in a resident ' s windpipe that provides an alternative airway for breathing), dependence on respirator (a machine that provides the breath when a resident is unable to breathe on their own), diabetes mellitus (a group of disease that affect how the body uses blood sugar), and bipolar disorder (a serious mental illness that causes unusual shifts in mood, ranging from extreme highs to lows). A record review of Resident 1 ' s Minimum Data Set (MDS - a standardized assessment and care planning tool) dated 3/6/2023 indicated Resident 1 ' s cognition (ability to think and make decisions) was intact. The MDS further indicated that Resident 1 needed limited assistance from staff with eating and extensive assistance from staff with bed mobility (movement), transfer, and toilet use. A record review of the Facility Census List (a documentation that indicates the residents admitted and residing in the facility) for 1/2023 and 2/2023, indicated that Resident 1 was transferred to the General Acute Care Hospital (GACH) on 1/16/2023 and returned to the facility on [DATE]. A record review of Resident 1 ' s physician order, dated 2/28/2023 indicated, to admitted Resident 1 back to the facility under the care of Primary Care Provider 1 (PCP 1) . A review of Resident 1 ' s Progress Note documented by NP 1, dated 1/22/2023 indicated that Resident 1 was in bed comfortably without complaints. NP 1 documented Resident 1 ' s vital signs (essential body functions, including your heartbeat, breathing rate, temperature, and blood pressure) as follows: 1. Heart rate (number of heart beats per minute with normal range of 60-100 heart beats per minute) of 78. 2. Respiration Rate (number of breaths taken per minute with normal range from 14-20) of 18. 3. Blood Pressure (measurement of pressure within the walls of the heart; normal reference range is 120/70 millimeters of Mercury [mmHg]) of 111/65 mmHg. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Temperature (the specific degree [ ] of hotness or coldness of the body; normal range is 97 Fahrenheit [F-unit of measure] to 99 F) of 98.6 F. A review of Resident 1 ' s Progress Note documented by NP 1, dated 2/6/2023 indicated that Resident 1 was comfortably in bed. The note further indicated that Resident 1 was not in acute distress (a sudden onset of pain or discomfort that is related to a resident ' s health) with no fever (a temporary rise in body temperature) or shortness of breath. NP 1 documented Resident 1 ' s vital signs as follows: 1. Heart rate of 76. 2. Respiration Rate of 19. 3. Blood Pressure of 128/69 mmHg. 4. Temperature of 98.2 F. A review of Resident 1 ' s Progress Note documented by NP 1, dated 2/21/2023 indicated that Resident 1 was comfortably in bed with no complaints. NP 1 documented Resident 1 ' s vital signs as follows: 1. Heart rate of 79. 2. Respiration Rate of 17. 3. Blood Pressure of 132/79 mmHg. 4. Temperature of 98.4 F. During an interview and concurrent record review with the Director of Nursing (DON) on 4/24/2024 at 2:24 PM, reviewed the Facility Census List of 1/2023 and 2/2023; along with Resident 1 ' s Progress Notes written by NP 1 dated 1/22/2023, 2/6/2023 and 2/21/2023. DON stated that Resident 1 was transferred to the GACH on 1/16/2024 and did not return to the facility until 2/28/2023. The DON stated that NP 1 ' s Progress Notes dated 1/22/2023, 2/6/2023 and 2/21/2023 indicated that NP 1 had completed an assessment for Resident 1 on 1/22/2023, 2/6/2023 and 2/21/2023. The DON stated that Resident 1 was not in the facility on 1/22/2023, 2/6/2023 and 2/21/2023. DON stated that she could not answer how come NP 1 was able to document multiple progress notes indicated that Resident 1 had been assessed during 1/22/2023, 2/6/2023 and 2/21/2023, despite the fact that Resident 1 at the facility on those dates. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/24/2024 at 4:31 PM with NP 1, NP 1 stated that the progress notes for Resident 1 that were completed on 1/22/2023, 2/6/2023 and 2/21/2023, were completed by NP 1 despite the fact that Resident 1 was not at the facility . NP 1 stated that NP 1 could not believe how it happened and stated that it was a mistake. NP 1 stated that NP 1 conducts the assessments and evaluations of residents while in the facility. NP 1 stated that NP 1 does not complete the documentation of the assessments and evaluations until NP 1 arrives at home. When asked how NP 1 was able to obtain vital signs for Resident 1 on 1/22/2023, 2/6/2023 and 2/21/2023 despite the fact that Resident 1 was not at the facility on those days, NP 1 stated that NP 1 goes by memory and Resident 1 ' s documentation was done mistakenly. During an interview on 4/25/2024 at 1:01 PM with PCP 1, PCP 1 stated that NP 1 ' s progress notes dated 1/22/2023, 2/6/2023 and 2/21/2023, for Resident 1 were completed by NP 1 despite the fact that Resident 1 was not admitted at the facility during those dates. PCP 1 stated that NP 1 should have documented that Resident 1 was assessed on 1/22/2023, 2/6/2023 and 2/21/2023 as the resident was not at the facility on those dates. PCP 1 stated that it was a very busy time of year and NP 1 ' s workload was very high, and the progress notes were mistakenly done. A review of the facility policy and procedure (P&P) titled Charting and Documentation, undated, indicated that all services provided to the resident, progress toward the care plan goals, or any changes in the resident ' s medical, physical, functional, or psychosocial condition, shall be documented in the resident ' s medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident ' s condition and response to care .Documentation in the medical records will be objective, complete, and accurate. A review of the facility P&P titled Physician Progress Notes, with a revision date of February 2008, indicated physician progress notes must be maintained for each resident .physician progress notes reflect the resident ' s progress and response to his or her care plan. The resident ' s attending physician must write, sign and date the physician progress notes upon each visit.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 42275 Based on interview and record review, the facility failed to provide a safe, and comfortable environment for residents, staff and the public when on 1/7/2023, a stranger was able to enter the facility and steal food from the employee breakroom. This deficient practice placed the residents, staff, and the public safety at risk from issues such as theft. Findings: A review of the facility ' s Police Department Investigative Report dated 1/7/2023, indicated the following: 1. Date & Time of Occurrence: 1/7/2023 at 1:40 a.m. 2. Date & Time Reported to Police Department: 1/7/2023 at 8:20 a.m. 3. Type Property Stolen/Lost/Damaged: Chicken 4. Narrative information indicated that a suspect walked to the break room and selected chicken from the refrigerator, ate the chicken, and then left the location. During an interview with Registered Nurse 1 (RN 1) on 4/25/2024 at 6:20 a.m., RN 1 stated that facility staff locks the entrance door between 11 p.m. and 11:30 p.m. daily when the receptionist leaves. RN 1 stated that approximately 3 a.m., facility staff will then unlock the entrance door so that incoming staff can enter the facility. During an interview with Licensed Vocational Nurse 2 (LVN 2) on 4/25/2024 at 7:20 a.m., LVN 2 stated on 1/2023, but unable to recall the exact day, LVN 2 found a stranger inside the employee breakroom looking for food inside the refrigerator. LVN 2 stated that LVN 2 was unsure how the stranger was able to enter the facility. LVN 2 further stated that a stranger being able to enter the facility should never be allowed to occur for safety reasons. During a concurrent interview and record with the Administrator (ADM) on 4/25/2024 at 9:57 a.m., the ADM reviewed the Police Department Investigative Report dated 1/7/2023 and stated that the incident wherein a stranger was able to gain entry into the facility in the middle of the night on 1/7/2023 and ate chicken from the break room refrigerator should not have happened. ADM stated that there is a potential risk for accident affecting the residents and staff ' s safety. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility ' s policy and procedure (P&P) titled, Safety and Supervision of Residents, last reviewed in July/2023, indicated, Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting process . and a facility-wide commitment to safety at all levels of the organization.