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	09/09/2024

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39550 Based on interview and record review, the facility failed to follow its policy and procedure on Fall Management and Neurological (deals with problems affecting the nervous system [includes the brain, spinal cord, and a complex network of nerves]) Evaluation by failing to ensure a neurological assessment was completed after an unwitnessed fall on 8/17/2024 for one of three sampled residents (Resident 1). This deficient practice had the potential to result in a delay of care and placed the resident at risk of not receiving appropriate care due to incomplete resident medical care information that may lead to additional falls or complications. Findings: During a review of Resident 1's Admission Record indicated the facility admitted the resident on 8/10/2024 and readmitted on [DATE] with diagnoses that included sepsis (a serious condition in which the body responds improperly to an infection), autonomic neuropathy (occurs when there is damage to the nerves that control automatic body functions), muscle weakness, and repeated falls. During a review of Resident 1's Minimum Data Set (MDS - standardized assessment and care planning tool) dated 8/16/2024, indicated Resident 1's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was intact. The MDS indicated Resident 1 required substantial or maximal (helper does more than half the effort) assistance with oral hygiene, toileting hygiene, shower/bathing, and dressing. During a concurrent interview and record review on 9/9/2024 at 11:14 a.m., with the MDS Nurse (MDSN), the MDSN reviewed Resident 1's Change in Condition (COC- sudden deviation from a resident's baseline in physical, cognitive, behavioral, or functional domains) form dated 8/17/2024, timed at 6:33 p.m. The MDSN stated that on 8/17/2024, Resident 1 had an unwitnessed fall. The MDSN stated that after an unwitnessed fall, licensed nurses should complete a neurological assessment to monitor the resident's level of consciousness and monitor for any changes in condition. The MDSN further stated that if there are any changes noted, licensed nurses are to inform the resident's physician. The MDSN stated that a physician's order is not needed for a neurological assessment as it is part of nursing intervention and licensed nurse's documentation of monitoring a resident post fall. (continued on next page)

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

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

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F 0689

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

During a concurrent interview and record review on 9/9/2024 at 11:17 a.m., with the MDSN, Resident 1's Transfer Form dated 8/17/2024 at 10:17 p.m. was reviewed. The MDSN stated that Resident 1 was transferred to the hospital on 8/17/2024 at 9:20 p.m. for evaluation due to the fall.

During a concurrent interview and record review on 9/9/2024 at 11:18 a.m., with the MDSN, the MDSN reviewed Resident 1's Progress Notes dated 8/18/2024 at 4:52 a.m. and stated that Resident 1 returned to the facility.

During a concurrent interview and record review on 9/9/2024 at 12:30 p.m., with the Medical Records Director (MRD), Resident 1's Neurological Flow Sheet dated 8/17/2024 to 8/20/2024 was reviewed. The MRD stated that Resident 1's Neurological Flow Sheet was not completed.

During a concurrent interview and record review on 9/9/2024 at 1:04 p.m., with the Director of Nursing (DON), the DON reviewed Resident 1's Neurological Flow Sheet dated 8/17/2024 to 8/20/2024. The DON stated that Resident 1's Neurological Flow Sheet dated 8/17/2024 to 8/20/2024 was not completed and was not resumed after Resident 1's return to the facility from the hospital on 8/18/2024 at 4:52 a.m. because there was no order to resume the neurological assessment. The DON stated that the hospital should have given the facility orders to resume the neurological assessment. The DON further stated that it is the protocol of the facility that after an unwitnessed fall a neurological assessment should be done 72 hours post fall but because there is no physician's order after Resident 1 came back from the hospital the facility did not have to continue Resident 1's neurological assessment. The DON stated that a neurological assessment is a nursing intervention. When asked if nursing interventions need a physician's order, the DON stated no, and continued to state that nursing interventions do not need a physician's order. When asked what the facility should have done, the DON stated that the facility staff did not do anything wrong.

A review of Resident 1's Neurological Flow Sheet dated 8/17/2024 to 8/20/2024, indicated that the licensed nurse will complete the Neurological Flow Sheet for any unwitnessed fall, or witnessed fall with suspected or known head injury for sixty-six (66) hours following the fall. The attending physician will be informed if there is a deviation from the resident's normal status for further instruction. The document further indicated: Vital Signs (measurements of the body's most basic functions) and Neuro Check (also known as neuro evaluation - a series of questions and tests to check brain, spinal cord, and nerve function): every (q)15 minutes for one (1) hour; q 30 minutes for one hour; q one hour for four hours, then q four hours for 66 hours.

A review of the facility's policy and procedure titled Fall Management, last reviewed 7/2024, indicated that the purpose is to address injury and provide care for a fall. Patients experiencing a fall will receive appropriate care. If patient falls, observe, or check for injury; perform Neurological Evaluation for all unwitnessed falls and witnessed falls with injury to the head or face.

A review of the facility's policy and procedure titled Neurological Evaluation, last reviewed 7/2024, indicated neurological evaluation will be performed as indicated or as ordered. When a resident sustains an injury to the head or face and/or has an unwitnessed fall, neurological evaluation will be performed: every 15 minutes for two hours, then every 30 minutes for two hours, then every 60 minutes for four hours, then every eight (8) hours until at least 72 hours.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure titled Nursing Documentation, last reviewed 7/2024, indicated to communicate patient's status and provide complete, comprehensive, and accessible accounting of care and monitoring provided. Documentation includes information about the patient's status, nursing assessment and interventions, expected outcomes, evaluation of the patient's outcomes, and responses to nursing care.

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 39550

Based on interview and record review, the facility to implement their facility's pain management policy by failing to ensure Licensed Vocational Nurse 1 (LVN 1) notified the physician timely to obtain orders to treat residents' pain of for one of three sampled residents (Resident 1).

This deficient practice had the potential to result in Resident 1 to experience continued unrelieved pain on 8/18/2024 and not reach the highest possible level of comfort.

Findings:

During a review of Resident 1's Admission Record indicated the facility admitted the resident on 8/10/2024 and readmitted on [DATE] with diagnoses that included sepsis (a serious condition in which the body responds improperly to an infection), autonomic neuropathy (occurs when there is damage to the nerves that control automatic body functions), muscle weakness, and repeated falls.

During a review of Resident 1's Minimum Data Set (MDS - standardized assessment and care planning tool) dated 8/16/2024, indicated Resident 1's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was intact. The MDS indicated Resident 1 required substantial or maximal (helper does more than half the effort) assistance with oral hygiene, toileting hygiene, shower/bathing, and dressing.

During a review of Resident 1's Physician Orders, indicated an order for:

- Acetaminophen (medication used to relieve mild to moderate pain) 325 milligrams (mg- unit of measure), give two tablets by mouth every six (6) hours as needed for mild pain (pain rated at one to four on a pain scale from zero [0] to 10, where 10 is the worst possible pain), with order date of 8/16/2024.

- Gabapentin (medication used to treat neuropathic [a nerve problem that causes pain, numbness, tingling, swelling, or muscle weakness] pain) 100 mg, give one capsule by mouth three times a day (9:00 a.m.; 1:00 p.m.; and 5:00 p.m.), with order date of 8/10/2024.

- Tramadol (medication used to treat moderate to severe pain), give 12.5 mg by mouth every eight hours as needed for moderate pain (pain rated at five to seven on a pain scale), with order date of 8/10/2024.

During a review of Resident 1's Health Status Note dated 8/18/2024, timed at 1:32 p.m., indicated that on 8/18/2024 at 11:00 a.m., LVN 1 called the on-call physician after hours and holiday number to request for pain medication. The Health Status Note further indicated that LVN 1 was informed that an on-call physician would return his call however two hours had passed. LVN 1 made a follow-up call at 1:30 p.m. by contacting the on-call physician after hours and holiday number and was informed that the call cannot be answered due to technical difficulties.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 9/9/2024 at 11:51 a.m., with LVN 1, LVN 1 reviewed Resident 1's Health Status Note dated 8/18/2024, timed at 1:32 p.m. LVN 1 stated that on 8/18/2024 at 11:00 a.m., Resident 1 complained of pain despite administering Resident 1's pain medications as ordered. LVN 1 stated that he called Resident 1's physician to request for additional pain medication. LVN 1 stated that he was not able to contact Resident 1's physician because the facility has to go through a phone service, and the phone service was having technical difficulties. LVN 1 stated that he was unable to contact the doctor personally to get an additional order of pain medicine. When asked what LVN 1 did after, LVN 1 stated that he had endorsed it to the next shift (3:00 p.m. to 11:00 p.m. shift). LVN 1 continued to state that he was visually monitoring Resident 1 during the time he (LVN 1) was waiting for the physician to call back, and Resident 1 was asleep. When asked what LVN 1 should have done, LVN 1 stated that he should have called the medical director to ask for an order for pain medication and should not have just endorsed to the following shift. During an interview on 9/9/2024 at 1:56 p.m. with the Director of Nursing (DON), the DON stated that LVN 1 should have informed the DON, and the DON would have called the facility's medical director to inform him of Resident 1's request for pain medication. A review of the facility's policy and procedure titled Pain Management, last reviewed 7/2024, indicated to maintain the highest possible level of comfort for the resident by providing a system to identify, assess, treat, and evaluate pain. It is the policy of the facility to provide pain management that is consistent with professional standards of practice. The nurse will notify the physician as appropriate and obtain treatment orders as indicated.