

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555815	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/29/2024
NAME OF PROVIDER OR SUPPLIER Totally Kids Specialty Healthcare - Sun Valley		STREET ADDRESS, CITY, STATE, ZIP CODE 10716 LA Tuna Canyon 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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44309</p> <p>Based on interview, and record review, the facility failed to develop and implement comprehensive person-centered care plans (a plan of care that summarizes a resident's health conditions, specific care and services facility staff need to provide a resident to promote healing and prevent a worsening of a condition, and current treatments) to meet the residents' needs for six of six sampled residents (Resident 16, Resident 27, Resident 22, Resident 24, Resident 13 and Resident 39) by failing to:</p> <ol style="list-style-type: none"> 1. Develop and implement a comprehensive person-centered care plan addressing Resident 16's risk for development of pressure injury (localized damage to the skin and/or underlying tissue usually over a bony prominence). 2. Develop and implement a comprehensive person-centered care plan addressing Resident 27's bladder incontinence (the loss of bladder control). 3. Develop and implement a comprehensive person-centered care plan addressing Resident 22 and Resident 24's use of anticonvulsant medications (medication used to control seizures [a burst of uncontrolled electrical activity between brain cells that caused temporary abnormalities in muscle tone or movements]) 4. Develop and implement a comprehensive person-centered care plan addressing Resident 13's bowel and bladder toileting. 5. Develop and implement a comprehensive person-centered care plan addressing Resident 39's high fall risk. <p>These deficient practices had the potential to lead to the inadequate care of Resident 16, 27, 22, 24, 13 and 39).</p> <p>Findings:</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>1. During a review of Resident 16's Admission Record, the Admission Record indicated that the facility originally admitted the resident on 10/31/2022, and readmitted on [DATE], with diagnoses including cerebral palsy (a condition that affect movement and posture, caused by damage that occurs to the developing brain, most often before birth), contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion) of elbow and wrist, and encounter for attention to tracheostomy (an opening surgically created through the neck into the windpipe to allow air to fill the lungs).</p> <p>During a review of Resident 16's Minimum Data Set (MDS - a resident assessment tool) dated 11/6/2024, the MDS indicated that the resident's cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated that Resident 16 was dependent on the staff (helper does all of the effort) for oral hygiene, toileting hygiene, showering/bathing, upper and lower body dressing, and personal hygiene. The MDS further indicated that Resident 16 was at risk for developing pressure ulcers/injuries and had one stage one pressure injury (intact skin with a localized area of redness and/or changes in sensation, temperature, or firmness).</p> <p>During a review of Resident 16's Braden Q Assessment forms (a tool used to assess the risk for pressure ulcers in pediatric patients) dated 8/8/2024 and 11/6/2024, the forms indicated a score of 14 (score of 13-14 is considered moderate risk for pressure injury development). The forms indicated that Resident 16 was completely immobile (does not make even slight changes in body or extremity position without assistance), had very limited sensory perception (the ability to understand and interact with the environment using senses of sight, smell, hearing, taste, touch) and very moist skin (skin is often, but not always moist) and his spasticity (having stiff or rigid muscles) and contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion) led to almost constant thrashing (moving from side to side in an uncontrolled way) and friction (occurs when skin moves against support surface).</p> <p>During a review of Resident 16's physician order dated 10/21/2024, the physician order indicated to clean left buttock stage one pressure injury with discoloration with normal saline (NS-a solution of salt and water), pat dry and apply optifoam (an advanced wound care dressing) to the site during every shift for 14 days.</p> <p>During a review of Resident 16's care plans, there was no care plan developed and initiated to address Resident 16's risk for development of pressure injury.</p> <p>During a concurrent interview and record review on 12/28/2024 at 2:56 p.m., with MDS Nurse (MDS), Resident 16's care plans were reviewed. The MDS stated that she (MDS) is in charge of developing and updating residents 'care plans in the facility. The MDS stated that there is no long-term care plan developed for Resident 16's risk for pressure injury development. The MDS stated long term care plans are those care plans that are ongoing and risk for developing a pressure injury is one of the problems requiring a long-term care plan. The MDS stated the potential outcome of not developing a person-centered care plan for a resident at risk for developing pressure injuries is the inability to address the appropriate care and treatment that the resident needs and an increased risk for development of new pressure injuries.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 12/29/2024 at 2:46 p.m., with the facility's Director of Nursing (DON), the DON stated licensed staff are required to develop a care plan with appropriate goal and interventions based on the residents' problems and identified needs. The DON stated Resident 16 is bedridden and at risk to develop pressure injuries. The DON stated licensed staff did not develop a care plan for Resident 16's risk to develop a pressure injury. The DON stated the potential outcome is lack of care, monitoring, and the inability to deliver necessary interventions to prevent skin injuries.</p> <p>2. During a review of Resident 27's Admission Record, the Admission Record indicated that the facility admitted the resident on 6/25/2024, with diagnoses including quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury), neuromuscular dysfunction of the bladder (a problem in which a person lacks bladder control due to a brain, spinal cord, or nerve condition), and encounter for attention to tracheostomy (an incision in the windpipe made to help air and oxygen reach the lungs).</p> <p>During a review of Resident 27's Minimum Data Set (MDS - a resident assessment tool) dated 10/5/2024, the MDS indicated that the resident's cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was intact (decisions consistent/reliable). The MDS indicated that Resident 27 was dependent on the staff (helper does all of the effort) for oral hygiene, toileting hygiene, showering/bathing, upper and lower body dressing, and personal hygiene. The MDS further indicated that Resident 27 was always incontinent (no episodes of continent voiding) and required intermittent (not happening regularly or continuously) catheterization (a hollow tube inserted into the bladder to drain or collect urine).</p> <p>During a review of Resident 27's Physician order dated 6/27/2024, the order indicated to perform in and out catheterization every four hours during the day shift and every six hours during the night shift for neurogenic bladder (when a person lacks bladder control due to brain, spinal cord, or nerve problems). The order further indicated to perform bladder scan (a safe, painless, reliable procedure using a scanner that allows you to assess the volume of urine retained within the bladder) prior to the in and out catheterization. In the event that the urine volume is greater than 150 milliliters (ml-a unit of measurement) continue with catheterization. The order indicated to notify charge nurse and the physician if an in and out catheterization is needed.</p> <p>During a review of Resident 27's care plans, there was no care plan developed and implemented to address Resident 27's bladder incontinence.</p> <p>During a concurrent interview and record review on 12/29/2024 at 3:52 p.m., with the facility's Director of Nursing (DON), Resident 27's care plans were reviewed. The DON stated Resident 27 was admitted to the facility on [DATE]. However, licensed staff did not develop a comprehensive care plan with person-centered interventions addressing the resident's bladder incontinence. The DON stated Resident 27 is incontinent of bladder and licensed staff are performing in and out catheterization for the resident as ordered by the physician. The DON stated the potential outcome of not developing a person-centered care plan with goals and interventions for a resident who is incontinent of urine is the lack of care and the inability to implement the specific services that the resident requires.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During review of the facility's Policy and Procedure (P&P) titled, Resident Care Planning, reviewed 12/3/2024, the P&P indicated a comprehensive plan of care will be developed to meet each resident's medical, developmental, and psychosocial needs. This care plan will include the problems/needs identified in the Resident Assessment Instrument as well as other problems/needs as identified by the facility staff. The care plan is composed of the initial care plan, the long-term care plan, and the short-term care plan. Long-term care plans are those care plans that are ongoing and are reviewed at each care plan meeting. Each care plan will be person-centered and include problem statement, goals (stated in measurable/observable terms), approaches to meet the goal, discipline/staff responsible for the approach and reassessments and changes as needed.</p> <p>47883</p> <p>3.a. During a review of Resident 22's Admission Record, the Admission Record indicated the facility originally admitted the resident on 1/6/2020 with diagnoses including cerebral palsy (central nervous system [CNS] motor disorders which are characterized by impairment of voluntary muscle movement), anoxic brain damage (condition when the brain is completely deprived of oxygen, causing damage to brain cells due to a lack of necessary oxygen supply), and convulsion (sudden, uncontrolled shaking of the body muscles, often associated with seizures).</p> <p>During a review of History and Physical, dated 1/7/2024, the History and Physical indicated that Resident 22 had seizures.</p> <p>During a review of Resident 22's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 1/8/2024, the MDS indicated that the resident had severely impaired cognition (severely damaged mental abilities, including remembering things, making decisions, concentrating, or learning). The MDS further indicated that Resident 4 was totally dependent on staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive).</p> <p>During a review of Resident 22 Order Summary Report dated December 2024, the Order Summary Report indicated that Resident 22 had an order for:</p> <p>-Lorazepam (medication used to treat a seizure disorders) .5 milligram (mg - unit of measurement) give 1 tab via G- Tube (a tube inserted through the abdomen to deliver nutrition and medications directly to the stomach) three times a day for seizures (sudden burst of uncontrolled electrical activity in the brain) dated 01/11/2023.</p> <p>During a review of Resident 22 Medication Administration Record (MAR) for 12/2024, the MAR indicated that Resident 22 received Lorazepam .5 mg from 12/1/2024 through 12/28/2024, three times a day every day.</p> <p>During a concurrent interview and record review on 12/29/2024 at 4:04 p.m., with the Minimum Data Set Nurse (MDSN), the MDSN reviewed Resident 22's care plans (a document that outlines a patient's health information, conditions, treatments, care services, and goals). The MDS was asked if Resident 22 had a care plan addressing that Resident 22 is receiving antiseizure medication. The MDS stated she could not find any, but she knows that there is requirement to develop care plan if a resident is on high risk antiseizure medications.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3.b. During a review of Resident 24's Admission Record, the Admission Record indicated the facility originally admitted the resident on 5/2/2024 with diagnoses including injury of cervical spinal cord (a damage to the to the nerves that send and receives signals brain), severe intellectual disabilities (someone has significant limitation in their ability to learn, understand, and communicate), and convulsion (sudden, uncontrolled shaking of the body muscles, often associated with seizures).</p> <p>During a review of Resident 24's MDS dated [DATE], the MDS indicated that the resident had severely impaired cognition (severely damaged mental abilities, including remembering things, making decisions, concentrating, or learning). The MDS further indicated that Resident 4 was totally dependent on staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive).</p> <p>During a review of Resident 24 Order Summary Report dated December 2024, the Order Summary Report indicated that Resident 24 had an order for:</p> <p>-Keppra (medication used to treat a seizure disorders) 500 milligram (mg - unit of measurement) give 1 tab via G- Tube (a tube inserted through the abdomen to deliver nutrition and medications directly to the stomach) two times a day for seizures dated 01/11/2023.</p> <p>During a review of Resident 24 Medication Administration Record (MAR) for 12/2024, the MAR indicated that Resident 24 received Keppra 500 mg from 12/1/2024 through 12/28/2024, two times a day every day.</p> <p>During a concurrent interview and record review on 12/29/2024 at 4:04 p.m., with the Minimum Data Set Nurse (MDS), the MDSN reviewed Resident 24's care plans. The MDS was asked if Resident 22 had a care plan addressing that Resident 24 is receiving antiseizure medication. The MDS stated she could not find any, but she knows that there is requirement to develop care plan if a resident is on high risk antiseizures medications.</p> <p>During an interview and concurrent record review with the Director of Nursing (DON) on 12/29/2024 at 4:34 p. m., the DON reviewed Resident 22's and Resident 24's medical record and stated that the facility missed initiating a care plan for Resident 22 and Resident 24's use of antiseizure medication. The DON stated that there should have been a care plan on the residents' use of anti-seizure medications because the care plan will provide specific interventions regarding these medications.</p> <p>39550</p> <p>4. During a review of Resident 13's Admission Record, the Admission Record indicated the facility admitted the resident on 2/1/2018, with diagnoses including other specified congenital (present from birth) malformations, congenital malformation of brain, and encounter for attention to tracheostomy (a procedure to help air and oxygen reach the lungs by creating an opening into the trachea (windpipe) from outside the neck).</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 13's MDS dated [DATE], the MDS indicated the resident cognitive skills (cognition refers to conscious mental activities, and include thinking, reasoning, understanding, learning, and remembering) for daily decision-making was severely impaired. The MDS further indicated Resident 13 required supervision or touching assistance with staff with eating, required partial/moderate assistance with oral hygiene, and substantial/maximal assistance with toileting hygiene, shower, and personal hygiene.</p> <p>During a review of Resident 13's Bowel Evaluation dated 10/31/2024, the evaluation indicated Resident 13 is on an ongoing toileting program.</p> <p>During a review of Resident 13's Bladder Evaluation dated 10/31/2024, the evaluation indicated Resident 13 is on an ongoing toileting program.</p> <p>During an interview and concurrent record review with Registered Nurse 2 (RN 2) on 12/28/2024 at 3:09 p.m., RN 2 stated that Resident 13 is currently on a bowel and bladder toileting program. RN 2 stated that staff offer and have Resident 13 sit on the toilet to assist in toileting. RN 2 reviewed Resident 13's care plans from 10/31/2024-12/28/2024 and was unable to find a care plan for bowel and bladder toileting program.</p> <p>During an interview and concurrent record review with the Director of Nursing (DON) on 12/28/2024 at 3:49 p.m., the DON reviewed Resident 13's care plans from 10/31/2024-12/28/2024 and stated that the facility missed developing a care plan for Resident 13's bowel and bladder toileting. The DON stated that Resident 13's care plan on bowel and bladder toilet training is important because the care plan should provide specific interventions regarding bowel and bladder toileting.</p> <p>5. During a review of Resident 39's Admission Record, the Admission Record indicated the facility admitted the resident on 9/26/2024, with diagnoses including other specified congenital malformations, congenital malformation of brain, encounter for attention to tracheostomy, and dependence of respirator (ventilator- a machine or device used medically to support or replace the breathing of a person) status</p> <p>During a review of Resident 39's MDS, dated [DATE], the MDS indicated the resident cognitive skills for daily decision-making was severely impaired. The MDS further indicated Resident 39 was dependent with oral hygiene, toileting hygiene, shower, and personal hygiene.</p> <p>During an interview and concurrent record review with the Minimum Data Set Nurse (MDSN) on 12/28/2024 at 5:28 p.m., the MDSN reviewed Resident 39 Fall Risk assessment dated [DATE]. The MDS stated that Resident 39 is a high risk for fall. The MDS reviewed Resident 39's care plan from 9/26/2024-12/28/2024 and stated that there was no documented evidence of a care plan for high fall risk for Resident 39. The MDS stated that Resident 39 should have a care plan for high risk for fall so that facility staff will know specific interventions that will prevent a fall incident.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility's policy and procedure (P&P) titled Resident Care Planning, reviewed 10/11/2023, the P&P indicated a comprehensive plan of care will be developed to meet each resident's medical, developmental and psychosocial needs. This care plan will include the problem/needs identified in the Resident Assessment Instrument as well as other problems/needs as identified by the facility staff. Each care plan will include, as appropriate: 1.1 Problem statement; 1.2 Goals (stated in measurable/observable terms); 1.3 Approaches to meet the goals; 1.4 Discipline/Staff responsible for the approach; 1.5 Reassessments and changes needed.</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44309</p> <p>Based on interview, and record review, the facility failed to ensure one of one sampled resident (Resident 16) with limited range of motion (ROM- full movement potential of a joint) received appropriate treatment and services to prevent further decrease in range of motion by failing to:</p> <ol style="list-style-type: none"> 1. Provide Passive Range of Motion (PROM-when an outside force such as a therapist exclusively causes movement of a joint) exercises as ordered by the physician. 2. Develop and implement a person-centered care plan (a plan of care that summarizes a resident's health conditions, specific care and services facility staff need to provide a resident to promote healing and prevent a worsening of a condition, and current treatments) for Resident 16's contracture. <p>These deficient practices had the potential to put the resident in further decline of his range of motion and developing increased contractures (condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints).</p> <p>Findings:</p> <p>During a review of Resident 16's Admission Record, the Admission Record indicated that the facility originally admitted the resident on 10/31/2022, and readmitted on [DATE], with diagnoses including cerebral palsy (a condition that affect movement and posture, caused by damage that occurs to the developing brain, most often before birth), contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion) of elbow and wrist, and encounter for attention to tracheostomy (an opening surgically created through the neck into the windpipe to allow air to fill the lungs).</p> <p>During a review of Resident 16's Minimum Data Set (MDS - a resident assessment tool) dated 8/7/2023, the MDS indicated that the resident's cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated that Resident 16 had functional limitation in ROM in his upper and lower extremities. The MDS further indicated that Resident 16 was dependent on the staff (helper does all of the effort) for bed mobility, dressing, toilet use, personal hygiene, and transfer.</p> <p>During a review of Resident 16's physician order dated 4/2/2024, the order indicated for the nursing staff to perform PROM to the bilateral lower extremities (BLE-both legs) twice a day seven times a week as tolerated.</p> <p>During review of Resident 16's physician order dated 7/3/2024, the order indicated for the nursing staff to perform PROM to the bilateral upper extremities (BUE-both arms) twice a day seven times a week as tolerated for contracture management.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 16's Restorative Treatment Record (program that help residents to maintain their function and joint mobility) for BUE and BLE from 12/1/2024 to 12/28/2024, the record indicated no entries for treatment to the BLE and the BUE on 12/2/2024, 12/3/2024, and 12/7/2024 during the day and night shifts. The record indicated no entries for treatment to the BLE and the BUE on 12/6/2024, 12/20/2024, 12/25/2024, 12/26/2024, and 12/27/2024 during the day shift. The record further indicated no entries for treatment to the BLE and the BUE on 12/8/2024-12/9/2024, 12/13/2024-12/15/2024 during the night shift.</p> <p>During an observation on 12/28/2024 at 12:22 p.m., inside Resident 16's room, Resident 16 was observed laying on his back in the bed. Resident 16 was able to move his right arm and hand, his left wrist was bent towards his body and his both knees were in bent position.</p> <p>During a concurrent interview and record review on 12/29/2024 at 12:49 p.m., with Licensed Vocational Nurse 1 (LVN 1) Resident 16's Restorative Treatment Record for 12/2024 was reviewed. LVN 1 stated based on Resident 16's physician order, the nursing staff is required to provide PROM exercises to the BLE and the BUE twice daily, once per shift. The LVN 1 stated that there is no documentation available to show that the ordered treatment was provided to Resident 16 on 12/2/2024, 12/3/2024, and 12/7/2024 during the day and night shifts, on 12/6/2024, 12/20/2024, 12/25/2024, 12/26/2024, and 12/27/2024 during the day shift and on 12/8/2024-12/9/2024, 12/13/2024-12/15/2024 during the night shift. The LVN 1 stated sometimes the staff forget to document that they (staff) had provided the treatment. LVN 1 stated if it is not documented it is considered not done. LVN 1 stated staff are required to document every time they provide PROM to the residents. LVN 1 stated the potential outcome of not providing PROM exercises as ordered by the physician to a resident who has contracture is worsening of the resident's contracture.</p> <p>During a concurrent interview and record review on 12/29/2024 at 1:20 p.m., with the Director of Nursing (DON), Resident 16's Restorative Treatment Record for 12/2024 and care plans were reviewed. The DON stated Resident 16's physician ordered to provide PROM exercised to the BLE and the BUE twice daily as tolerated. However, based on the resident's Restorative Treatment Record for December 2024, there were some days that the treatment was not documented. The DON stated it is either the staff performed the treatment, and they did not document, or the treatment was not provided to the resident. The DON stated Resident 16 was admitted to the facility with both leg and arm contracture and providing the resident PROM is very important to prevent the resident's contractures from worsening. from developing from increased contractures. The DON stated if the PROM treatment was not documented it would be considered not provided. The DON stated the potential outcome of not providing PROM exercises to a resident with contracture is the worsening of contracture, decrease in ROM and harm to the resident. The DON stated licensed staff are required to develop a person-centered care plan based on the residents' needs and identified problems. The DON stated licensed staff did not develop a care plan with goal and interventions for Resident 16's contracture and PROM exercises. The DON stated that the potential outcome of not developing a care plan for Resident 16's contracture and PROM exercises is the inability to monitor to see if there are any decline/improvement in the resident's condition and consequently providing inadequate care to the resident.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Totally Kids Specialty Healthcare - Sun Valley		STREET ADDRESS, CITY, STATE, ZIP CODE 10716 LA Tuna Canyon Road Sun Valley, CA 91352	
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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During review of the facility's Policy and Procedure (P&P) titled, Range of Motion Exercises and Application of Orthotic Devices, reviewed 12/3/2024, the P&P indicated that ROM exercises and application of orthotic devices will be performed by the nursing staff under the direction of the Director of Nursing in collaboration with the Rehabilitation Team. After obtaining appropriate physician orders based on the rehabilitation recommendations, the nursing staff will carry over ROM exercises and orthotic application as recommended by the rehabilitation staff. Licensed staff will document on Restorative Charting Record immediately following all nursing assigned ROM exercises that are performed and splint/orthotic device applications. If ROM exercises are not performed or splint/orthotic devices are not applied, the appropriate space will be circled, and reason will be documented on the backside of the treatment record. Two gaps in the treatment record are not acceptable documentation.</p> <p>During review of the facility's Policy and Procedure (P&P) titled, Resident Care Planning, reviewed 12/3/2024, the P&P indicated a comprehensive plan of care will be developed to meet each resident's medical, developmental, and psychosocial needs. This care plan will include the problems/needs identified in the Resident Assessment Instrument as well as other problems/needs as identified by the facility staff. Care plans will be reviewed within 14 days of admission, monthly for the first quarter, quarterly thereafter and with any significant change in diagnosis or condition of the RAI or a significant change.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>39550</p> <p>Based on observation, interview, and record review the facility failed to ensure a resident with a physician's order to wear a soft helmet when out of the crib was wearing the soft helmet when the resident was out of the crib for one of three sampled residents (Resident 13)</p> <p>This deficient practice placed Resident 13 at risk for injury if a fall incident occurred.</p> <p>Findings:</p> <p>During a review of Resident 13's Admission Record, the Admission Record indicated the facility admitted the resident on 2/1/2018, with diagnoses including other specified congenital (present from birth) malformations, congenital malformation of brain, and encounter for attention to tracheostomy (a procedure to help air and oxygen reach the lungs by creating an opening into the trachea (windpipe) from outside the neck).</p> <p>During a review of Resident 13's Minimum Data Set (MDS - an assessment and care screening tool), dated 2/1/2024, the MDS indicated the resident's cognitive skills (cognition refers to conscious mental activities, and include thinking, reasoning, understanding, learning, and remembering) for daily decision-making was severely impaired. The MDS further indicated Resident 13 required supervision or touching assistance with staff with eating, required partial/moderate assistance with oral hygiene, and substantial/maximal assistance with toileting hygiene, shower, and personal hygiene.</p> <p>During a review of Resident 13's order summary report, the report indicated an order dated 5/26/2020 to place a soft helmet on head when out of crib except when in stroller.</p> <p>During a review of Resident 13's care plan for at risk for injury/falls related to impaired safety awareness revised on, 11/8/202, the care plan indicated under interventions: Helmet.</p> <p>During an observation in the activities room on 12/28/2024 at 12:07 p.m., observed Resident 13 ambulating independently from a table to a sink, observed Resident 13 wash her hands, then observed Resident 13 walk back to the table in the activity room without the helmet on.</p> <p>During an interview with Registered Nurse 2 (RN 2) on 12/28/2024 at 3:36 p.m., RN 2 stated that Resident 13 should be wearing her helmet while not in bed so that Resident 13 will not hit her head. RN 2 stated that it is the responsibility of all staff to ensure Resident 13's helmet is on for the safety of the resident.</p> <p>During a review of the facility's policy and procedure titled Physicians Orders, dated 2/5/2023, the policy and procedure indicated all orders will be carried out completely and noted in a timely manner.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>44309</p> <p>Based on interview and record review, the facility failed to ensure one of two sampled residents (Resident 26) received the appropriate treatment and services for bladder incontinence (the loss of bladder control) by failing to apply warm compress and bladder massage prior to the in and out catheterization and failing to perform in and out catheterization (when the catheter is inserted and left in only long enough to empty the bladder and then is removed) as ordered by the physician.</p> <p>This deficient practice had the potential to result in the inadequate care and monitoring of Resident 26 and placed him at an increased risk of infection.</p> <p>Findings:</p> <p>During a review of Resident 26's Admission Record, the Admission Record indicated that the facility admitted the resident on 9/15/2022, with diagnoses including anoxic brain damage (brain damage from a lack of oxygen to the brain), epilepsy (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness), personal history of urinary infections (UTI- an infection in the bladder/urinary tract), and persistent vegetative state (patients that are unaware of themselves or their environment for a long time).</p> <p>During a review of Resident 26's Minimum Data Set (MDS -a resident assessment tool) dated 9/18/2024, the MDS indicated the resident was in a persistently vegetative state. The MDS indicated that Resident 26 was dependent on staff (helper does all of the effort) for oral hygiene, toileting hygiene, showering/bathing, personal hygiene, and upper and lower body dressing. The MDS further indicated that Resident 26 was always incontinent (no episodes of continent voiding) and required intermittent (not happening regularly or continuously) catheterization (a hollow tube inserted into the bladder to drain or collect urine).</p> <p>During a review of Resident 26's Physician order dated 2/8/2024, the order indicated to perform bladder scan (a safe, painless, reliable procedure using a scanner that allows you to assess the volume of urine retained within the bladder) four times a day for neurogenic bladder (when a person lacks bladder control due to brain, spinal cord, or nerve problems). In the event that the scan presents 300 milliliter (ml-a unit of measurement) or more of urine, staff is required to perform in and out catheterization. The order indicated to notify charge nurse and the physician if an in and out catheterization is needed.</p> <p>During a review of Resident 26's Physician order dated 4/2/2024, the order indicated that prior to performing an in and out catheterization, a warm compress should be applied along with a five-minute bladder massage. If these measures prove ineffective after 30 minutes and the bladder scan revealed 300 ml of urine, proceed with the in and out catheterization and notify the charge nurse or the physician.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 26's Care Plan (CP-a document that outlines how a patient's health care needs will be met) for at risk for UTI related to neurogenic bladder initiated on 6/13/2023, the care plan indicated a goal that the resident will be free from urinary tract infections through review date. The care plan indicated an intervention to perform bladder scan, if 300 ml or more urine is present to perform in and out catheterization and notify the charge nurse and the physician whenever in and out catheterization is needed.</p> <p>During a review of Resident 26's Treatment Administration Record (TAR-) dated 11/1/2024-11/24/2024, the record indicated that the resident's bladder scan results were 493 ml on 11/17/2024 at 9 a.m., and 450 ml on 11/19/2024 at 3 a.m. The TAR did not indicate warm compress and a five-minute bladder massage, and in and out catheterizations were performed for Resident 26 on 11/17/2024 and 11/19/2024 as ordered by the physician.</p> <p>During a review of Resident 26's Treatment Administration Record (TAR- a daily documentation record used by a licensed nurse to document treatments given to a resident) dated 12/1/2024-12/29/2024, the record indicated that the resident's bladder scan results were 320 ml on 12/5/2024, and 480 ml on 12/26/2024 at 3 a.m. The TAR did not indicate warm compress and a five-minute bladder massage, and in and out catheterizations were performed on 12/5/2024 and 12/26/2024.</p> <p>During a concurrent interview and record review on 12/29/2024 at 12:20 p.m., with Licensed Vocational Nurse 1 (LVN 1), Resident 26's TAR for 12/2024 and nursing progress notes were reviewed. LVN 1 stated there is a physician order to perform bladder scan for Resident 26 four times a day. The LVN 1 stated also there is a physician order to apply a warm compress and to conduct a bladder massage prior to the in and out catheterization in order to assist Resident 26 to void on his own. LVN 1 stated she normally document interventions applied prior to Resident 26's catheterization in the nursing progress notes. The LVN 1 stated based on Resident 26's TAR for 12/2024, on 12/5/2024, Resident 26's bladder scan was 320 ml, and on 12/26/2024 it was 480 ml at 3 a.m. LVN 1 stated that there is no documentation in Resident 26's TAR or nursing progress notes indicating whether or not the assigned licensed nurse applied warm compress and bladder massage prior to the in and out catheterization or if the assigned nurse performed in and out catheterization for Resident 26. LVN 1 stated licensed staff did not follow Resident 26's physician orders to apply warm compress and massage the bladder and to perform in and out catheterization after implementing the required steps for Resident 26 on 12/5/2024 and 12/26/2024. The potential outcome of not following the physician orders is urinary retention (when you are unable to empty all the urine from your bladder) and the resident experiencing discomfort.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 12/29/2024 at 2:10 p.m., with the Director of Nursing (DON), Resident 26 `s TARs for 11/2024 and 12/2024, nursing progress notes, and physician orders were reviewed. The DON stated Resident 26` s physician ordered a bladder scan four times a day. The DON stated the physician order also indicated that if the bladder scan shows 300 ml or more of urine, an in and out catheterization should be performed. However, prior to the catheterization the licensed staff are required to perform less invasive interventions (intervention that does not require inserting an instrument through the skin or into a body opening) such as applying a warm compress and bladder massage to assist the resident with urinating. The DON stated licensed staff are required to document whether or not they applied the warm compress and conducted a bladder massage to the resident prior to in and out catheterization and also to document whether or not the in and out catheterization was performed per the physician orders. The DON stated licensed staff did not document in Resident 26` s TAR or nursing progress notes that they (licensed staff) performed in and out catheterization after a warm compress and a bladder massage was provided to Resident 26 on 11/17/2024, 11/19/2024, 12/5/2024 and 12/26/2024. The DON stated the potential outcome of not following the physician`s order regarding in and out catheterization is placing Resident 26 at increased risk for UTI.</p> <p>During a review of the facility`s Policy and Procedure (P&P) titled Urinary Catheterization, last reviewed 12/3/2024, the P&P indicated to document the time catheterization is completed, resident`s tolerance, amount, color, odor of urine and if specimen was sent to lab.</p> <p>During a review of the facility`s Policy and Procedure (P&P) titled Physician Orders, last reviewed 12/3/2024, the P&P indicated that the physician would give orders for medications, lab work, treatment, diet changes, admission, and consultation. Orders will be taken verbally, written, or via telephone. All orders will be carried out completely and noted in a timely manner.</p> <p>During a review of the facility`s Policy and Procedure (P&P) titled Documentation-Licensed Nursing Staff, last reviewed 2/5/2023, the P&P indicated that record of medication and treatments must be documented on the Medication administration Records (MAR) or Treatment Sheet at the time they are administered or performed. PRN (as needed) treatments or medication administered are to include the date, time, reason for administration and the effectiveness including the time of results. PRN treatments are to be administered according to the frequency prescribed.</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39550</p> <p>Based on interview and record review, the facility failed to implement their policy on intake and output by failing to ensure licensed nurses documented the residents output every shift for two of two sampled residents (Resident 18 and 8).</p> <p>This deficient practice had the potential to place Resident 18 and Resident 8 at risk for dehydration (deficit of total body water, with an accompanying disruption of body processes).</p> <p>Findings:</p> <p>a. During a review of Resident 18's Admission Record, the Admission Record indicated the facility admitted the resident on 10/8/2012, with diagnoses including spastic diplegic cerebral palsy (characterized by jerky movements, muscle tightness, and joint stiffness), encounter for attention to tracheostomy (a procedure to help air and oxygen reach the lungs by creating an opening into the trachea (windpipe) from outside the neck), dependence on respirator (ventilator) status, encounter for attention to gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), and constipation (a condition in which there is difficulty in emptying the bowels, usually associated with hardened feces).</p> <p>During a review of Resident 18's Minimum Data Set (MDS - an assessment and care screening tool), dated 10/2/2024, the MDS indicated the resident is in a persistent vegetative state/no discernible consciousness. The MDS further indicated Resident 18 was dependent on staff with oral hygiene, toileting hygiene, shower, and personal hygiene.</p> <p>During a review of Resident 18's order summary report, the report indicated the following order:</p> <p>- Enteral Feed Order: five times a day Jevity 1.2 135 mL (milliliters- unit of measurement)/hr (hour) set pump rate to 90mL. Start date: 7/12/2024.</p> <p>During a review of Resident 18's care plan for potential for impaired fluid balance related to dependence on enteral tube revised on 10/15/2024, the care plan indicated an intervention to monitor and document intake and output as per facility policy.</p> <p>During an interview and concurrent record review with the Director of Nursing (DON) on 12/29/2024 at 4:21 p. m., the DON stated that residents' intake and output information is documented on the resident's Treatment Administration Record (TAR). The DON reviewed Resident 18's TAR for the month of December 2024 and stated that there is no documented evidence of Resident 18's total output every shift. The DON stated that the total output of a resident is important to monitor and document to ensure residents do not become at risk for dehydration. The DON stated the facility needs to make sure that Resident 18 is well hydrated to help with Resident 18's constipation.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>b. During a review of Resident 8's Admission Record, the Admission Record indicated the facility admitted the resident on 10/4/2011, with diagnoses including spastic quadriplegic cerebral palsy (a permanent neuromuscular [relating to nerves and muscles] disorder causing limitation on all four limbs following a lesion on the developing brain), encounter for attention to tracheostomy, encounter for attention to gastrostomy .</p> <p>During a review of Resident 8's MDS, dated [DATE], the MDS indicated the resident cognitive skills for daily decision-making was severely impaired. The MDS further indicated Resident 8 was dependent on staff with oral hygiene, toileting hygiene, shower, and personal hygiene.</p> <p>During s review of Resident 8's order summary report, the report indicated the following order:</p> <p>-Enteral Feed Order: five times a day Compleat 1.0 at 165mL/hr via pump. Start date: 10/11/2024.</p> <p>During a concurrent interview and record review with the Director of Nursing (DON) on 12/29/2024 at 5:39 p. m., the DON stated that residents' intake and output information is documented on the resident's Treatment Administration Record (TAR). The DON reviewed Resident 8's TAR for the month of December 2024 and stated that there is no documented evidence of Resident 8's total output every shift. The DON stated the output will help determine if residents are in fluid overload. The DON stated that the total output of a resident is important to document so staff can monitor Resident 8's output and hydration status.</p> <p>During a review of the facility's policy and procedure (P&P) titled Intake and Output, reviewed 8/25/2023, the P&P indicated the Charge nurse will ensure that each resident is evaluated each shift for adequate hydration. Record intake and output at the end of each shift. Evaluate the intake and output to determine adequate or excessive. Daily intake and output will be documented in the resident's record.</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>47883</p> <p>Based on observation, interview, and record review, the facility failed to implement their enteral tube feeding (gastrostomy tube - GT, a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) policy and procedure (P&P) for one of four sampled residents (Resident 4) investigated for gastrostomy tube care by failing to label Resident 4's y-connector (a silicone tube used for patient with gastrostomy to deliver nutrition and medications directly to the stomach) with the date it was last changed.</p> <p>This deficient practice had the potential to place Resident 4 at an increased risk of infection and may cause adverse reactions (an undesired effect of a treatment) such as upset stomach and/or diarrhea (loose, watery stool more frequently than normal).</p> <p>Findings:</p> <p>During a review of Resident 4's Admission Record, the Admission Record indicated that the facility initially admitted Resident 4 on 1/15/2018, with diagnoses including encephalopathy (brain disease, damage, or malfunction of brain), acute and chronic respiratory failure with hypoxia (a serious condition that occurs when the air sacs of the lungs cannot release enough oxygen into the blood), and cerebral palsy (central nervous system [CNS] motor disorders which are characterized by impairment of voluntary muscle movement).</p> <p>During a review of Resident 4's Minimum Data Set (MDS - a resident assessment tool), dated 1/15/2024, the MDS indicated that the resident had severely impaired cognition (severely damaged mental abilities, including remembering things, making decisions, concentrating, or learning). The MDS further indicated that Resident 4 was totally dependent on staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive).</p> <p>During the review of Resident 4's History and Physical, dated 1/15/2024, the History and Physical indicated that Resident 4 had a GT in place.</p> <p>During the review of Resident 4's Order Summary Report, the Order Summary Report indicated an order dated 12/25/2022 for a GT y-connector change every night shift every Sunday.</p> <p>During a medication administration observation on 12/29/2024 at 8:30 a.m. inside Resident 4's room, observed Licensed Vocational Nurse 3 (LVN 3) administer one (1) tablespoon of Nutri source (a fiber powder to help support digestive health and normal bowel function) diluted in 60 ml (ml- unit of measurement) of water via the y-connector of the GT to the resident. Observed the GT y-connector label undated. LVN 3 confirmed that there was no date indicated on the label of the y-connector.</p> <p>During an interview on 12/29/2024 at 8:40 a.m., with LVN 3, LVN 3 stated that the y-connector should be changed every Sunday and labeled with the date it was last changed so nursing staff will be aware when the next y-connector change is due. LVN 3 stated it is important to change Resident 4's y-connector timely to prevent microbial growth and risk of acquiring infection.</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/29/2024 at 4:34 p.m. with the Director of Nursing (DON), the DON stated that the GT y-connector should be changed every Sunday and labeled with the date it was last changed to prevent microbial growths and prevent the risk of Resident 4 acquiring infection.</p> <p>During a review of the facility policy and procedure titled Medication Administration, last reviewed on 10/24/2018, the policy stated facility to administer oral medication via enteral feeding tube in an organized, clean, and safe manner. If the enteral tube, or tube extension becomes contaminated, it must be discarded and replaced.</p>		

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NAME OF PROVIDER OR SUPPLIER Totally Kids Specialty Healthcare - Sun Valley		STREET ADDRESS, CITY, STATE, ZIP CODE 10716 LA Tuna Canyon Road Sun Valley, CA 91352	
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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>47883</p> <p>Based on interview and record review the facility failed to ensure residents who needed respiratory care (the health care discipline that specializes in the promotion of optimum cardiopulmonary function and health and wellness) was provided such care, consistent with professional standards of practice by failing to change the aerosol/ventilator (a machine that helps a person breathe by moving air in and out of their lungs) humidifier water bottle (equipment to produce and dispense water vapor, adding moisture to oxygen and restoring healthy level of humidity [the amount of water vapor in the air]) every three (3) days for one of three sampled resident (Resident 22) investigated for respiratory care.</p> <p>This deficient practice had the potential for Resident 14 to develop a respiratory infection.</p> <p>Findings:</p> <p>During a review of Resident 22's Admission Record, the Admission Record indicated the facility originally admitted the resident on 1/6/2020 with diagnoses including cerebral palsy (central nervous system [CNS] motor disorders which are characterized by impairment of voluntary muscle movement), anoxic brain damage (condition when the brain is completely deprived of oxygen, causing damage to brain cells due to a lack of necessary oxygen supply), and convulsion (sudden, uncontrolled shaking of the body muscles , often associated with seizures).</p> <p>During a review of History and Physical, dated 1/7/2024, the History and Physical indicated that Resident 22 needs mechanical ventilation (a life support technique that uses a machine to help a person breath).</p> <p>During a review of Resident 22's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 1/8/2024, the MDS indicated that the resident had severely impaired cognition (severely damaged mental abilities, including remembering things, making decisions, concentrating, or learning). The MDS further indicated that Resident 22 was totally dependent on staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive).</p> <p>During a review of Resident 22's care plan (a document that outlines the actions and interventions needed to address a resident's health and care needs), initiated on 4/5/2023 and revised on 11/20/24, the care plan indicated that Resident 22 was ventilator dependent. The goal in the care plan indicated that Resident 22 would remain free of complications related to ventilator dependence, including upper respiratory infection.</p> <p>During a review of Resident 22's Physician Order, dated 11/7/2024, there was a physician order for: FIO2 21% on cool aerosol (aerosol delivery device for respiratory therapy), may titrate up to 28% to maintain SPO2 (the percentage of oxygen your blood is carrying) above 94%.</p> <p>During an observation on 12/27/2024, at 9:27 AM, observed Resident 22 in his room on a ventilator with an aerosol /ventilator humidifier water bottle connected to Resident 22.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview on 12/27/2024 at 9:30 AM in Resident 22's room with Respiratory Care Practitioner 1 (RCP 1), RCP 1 observed and stated that the humidifier water bottle was not labeled with the date it was changed. RCP 1 stated that the ventilator humidifier water bottle should be changed every 3 days and PRN (as needed) according to the facility policy. RCP 1 stated that not changing the ventilator humidifier water bottle every three (3) days may lead to Resident 22 developing a respiratory infection.</p> <p>During an interview on 12/28/2024 at 4:11 p.m. with the Respiratory Department Supervisor (RDS), the RDS stated according to the facility policy Nursing Respiratory the humidifier water bottle should be changed every 3 day and is supposed to have a label indicating when it was last changed. The RDS stated not labeling the humidifier water bottle with the date when it was last changed has the potential to cause increased risk of healthcare acquired infection to Resident 22.</p> <p>During a review of the facility policy and procedure titled Nursing Respiratory, last reviewed on 6/30/2018, the policy indicated: All equipment is dedicated exclusively for the use of each resident. The following equipment to be maintained as outlined in table below and PRN. Equipment to be labeled with date of use . Aerosol/Ventilator humidifier water bottle to be changed every 3 days and PRN.</p>

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>39550</p> <p>Based on interview and record review, the facility failed to maintain complete and accurate medical records in accordance with accepted professional standards for one of three sampled residents (Resident 2) by failing to ensure a specific indication was written for an order of Augmentin (antibiotic- medication that fights bacterial infections).</p> <p>This deficient practice placed the resident at risk of not receiving appropriate care due to inaccurate resident medical care information and the potential to result in confusion in the care and services for Resident 2.</p> <p>Findings:</p> <p>During a review of Resident 2's Admission Record, the Admission Record indicated the facility originally admitted the resident on 7/21/2005 and readmitted the resident on 12/21/2023 with diagnoses that included congenital (present at birth) malformation of ear, unspecified visual loss, lack of expected normal physiological development in childhood.</p> <p>During a review of Resident 2's Minimum Data Set (MDS- a resident assessment tool) dated 9/23/2024, the MDS indicated Resident 2's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was intact. The MDS also indicated Resident 5 was independent oral hygiene, toileting hygiene, and personal hygiene.</p> <p>During a review of Resident 2's Order Summary Report, the Order Summary Report indicated an order for Augmentin ES-600 oral suspension reconstituted 600-42.3 milligrams (mg- unit of measurement)/5 milliliter (ml- unit of measurement). Give 6.5 ml via gastrostomy tube (g-tube, a tube inserted through the belly that brings nutrition directly to the stomach) two times a day for infection for seven days.</p> <p>During a concurrent interview and record review on 12/29/2024 at 10:46 a.m., with the Infection preventionist (IP), reviewed Resident 2's physician orders. The IP stated that Resident 2's physician order for Augmentin is missing the specific infection that the medication is targeting. The IP stated that the physician's order is not complete. The IP stated that it is important for all antibiotic medication orders to have a specific diagnosis with the order so staff will know what the antibiotic is targeting.</p> <p>During an interview on 12/29/2024 at 4:45 p.m., with the Director of Nursing (DON), the DON stated that all antibiotic orders should have a specific reason that the antibiotic is ordered for.</p> <p>During a review of the facility's policy and procedure titled, Medication Administration, reviewed 10/24/2018, the policy indicated physician ordered medication to be administered by licensed medical/nursing personnel. Check order on medication record with label on prescribed medication for proper resident name, medication, dosage, time, route, and rationale.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>39550</p> <p>Based on observation, interview, and record review, the facility failed to ensure drugs and biologicals were stored in accordance with accepted professional principals by failing to:</p> <ol style="list-style-type: none"> 1. Ensure staff did not leave two of two medication carts (Medication Cart A and B) unlocked and unattended and leave medications unattended. <p>This deficient practice had the potential for unsafe facility practices, unauthorized entry to the medication cart, and contamination of the prepared medications.</p> <ol style="list-style-type: none"> 2. Ensure two opened (in-use) olopatadine hydrochloride (HCL) solution (type of eye drops used to treat eye itching) 0.1% (measurement of concentration) vials were discarded after 30 days after opening for one of one sampled resident (Resident 24). 3. Ensure an expired antibiotic (a drug used to treat infections), nitrofurantoin (antibiotic used to treat urinary tract infections [UTI- an infection in the bladder/urinary tract]) was removed from the medication card and disposed of for one of one sampled resident (Resident 11). <p>These deficient practices had the potential for the residents to receive expired medications.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1.a. During an observation on 12/27/2024 at 6:35 p.m., observed Medication Cart A inside a resident's room unlocked and unattended. <p>During a concurrent observation and interview on 12/27/2024 at 6:36 p.m., with Respiratory Therapist 1 (RT 1), RT 1 stated RTs and licensed nurses have keys to the medication carts. RT 1 observed Medication Cart A and stated that the medication cart was left unlocked. RT 1 stated that RT 1 left Medication Cart A unattended for just a few seconds while she stepped into another room. RT 1 stated that she should not have left the medication cart unattended for safety.</p> <ol style="list-style-type: none"> 1.b. During an observation on 12/29/2024 at 8:21 a.m., observed Medication Cart B inside a resident's room unlocked with prepared medications in syringes on top of Medication Cart B unattended. <p>During a concurrent observation and interview on 12/29/2024 at 8:23 a.m., with Licensed Vocational Nurse 7 (LVN 7), observed Medication Cart B. LVN 7 stated that LVN 7 did leave Medication Cart B with prepared medication in syringes on top of the medication cart unattended while she went inside the restroom located in the resident's room. LVN 7 stated that she should not have left the medication cart with prepared medication in syringes on top of the medication cart unattended because anyone can get access to the medications, and it is not safe for the residents.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 12/29/2024 at 4:46 p.m., with the Director of Nursing (DON), the DON stated RTs and licensed nurses have access to the medications. The DON stated that it is important to make sure all medication carts are locked, and medication are not left unattended before stepping away from the medication cart to ensure unauthorized individuals do not have access to medications and for safety.</p> <p>During a review of the facility's policy and procedure titled, Storage of Medication, reviewed 01/2023, the policy indicated in order to limit access to prescription medication, only licensed nurses, pharmacy staff, and those lawfully authorized to administer medications are allowed access to medication carts. Medication rooms, cabinets and medication supplies should remain locked when not in use or attended by persons with authorized access.</p> <p>47883</p> <p>2. During a review of Resident 24's Admission Record, the Admission Record indicated the facility originally admitted the resident on 5/2/2024 with diagnoses including injury of cervical spinal cord (damage to the to the nerves that send and receives signals brain), severe intellectual disabilities (when someone has significant limitations in their ability to learn, understand, and communicate), and convulsion (sudden, uncontrolled shaking of the body muscles).</p> <p>During a review of Resident 24's Minimum Data Set (MDS - a resident assessment tool), dated 5/10/2024, the MDS indicated that the resident had severely impaired cognition (severely damaged mental abilities, including remembering things, making decisions, concentrating, or learning). The MDS further indicated that Resident 24 was totally dependent on staff with all activities of daily living (ADLs- activities related to personal care).</p> <p>During a review of Resident 24's Order Summary Report dated 12/2024, the Order Summary Report indicated that Resident 24 had an order for olopatadine HCl solution 0.1% (measurement of concentration) one drop in both eyes two times a day.</p> <p>During a review of Resident 24's Medication Administration Record (MAR- a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for 12/2024, the MAR indicated that Resident 24 received olopatadine HCl solution from December 1, 2024, through December 28, 2024, two times a day every day.</p> <p>During a concurrent observation and interview on 12/27/2024 at 9:58 p.m., with Licensed Vocational Nurse 4 (LVN 4), observed the contents of Medication Cart C. Observed one opened olopatadine HCl solution with an open date of 10/25/2024 and no beyond use date and one opened olopatadine HCl solution with an open date of 10/01/2024 and no beyond use date. LVN 4 confirmed by stating that the olopatadine HCl solutions should have been discarded 30 days after opening and should not have been in the medication cart.</p> <p>During an interview on 12/29/2024 at 4:34 p.m., with the DON, the DON stated it was important for medications not to be kept in the medication cart or used beyond their expiration date because the medication may be ineffective. The DON stated that if a medication was ineffective, then the resident's health condition may get worse or remain untreated.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility's policy and procedure titled, Medication Storage, last reviewed and revised on 1/2023, the policy and procedure indicated that drugs shall not be kept in stock after the expiration date on the label. No unusable drugs shall be stored, distributed, or administered. Outdated, contaminated, discontinued, or deteriorated medication are immediately removed from stock, disposed of according to procedure for medication disposal.</p> <p>44309</p> <p>3. During a review of Resident 11's Admission Record, the Admission Record indicated the facility admitted the resident on 7/10/2015 with diagnoses including epilepsy (a brain disorder that causes recurring abnormal electrical activity in the brain that temporarily affects your consciousness, muscle control and behavior), spastic quadriplegic cerebral palsy (a permanent neuromuscular disorder causing limitation on all four limbs following a lesion on the developing brain), and encounter for attention to gastrostomy (GT-a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems).</p> <p>During a review of Resident 11's MDS, the MDS indicated that the resident's cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated that Resident 11 was dependent on the staff (helper does all of the effort) for oral hygiene, toileting hygiene, showering/bathing, upper and lower body dressing, and personal hygiene. The MDS further indicated that Resident 11 was taking antibiotic.</p> <p>During a review of Resident 11's physician order dated 7/3/2023, the order indicated to administer five milliliters (ml-a unit of measurement) of nitrofurantoin oral suspension, 25 milligrams (mg- a metric unit of measurement for medications) in five ml, via GT at bedtime for UTI.</p> <p>During a review of Resident 11's MAR for 12/2024, the MAR indicated that the last date Resident 11 received nitrofurantoin was 12/28/2024.</p> <p>During a concurrent observation and interview on 12/29/2024 at 4:50 p.m., with Licensed Vocational Nurse 2 (LVN 2), observed Medication Cart D. Observed a bottle of nitrofurantoin with an expiration date of 12/25/2024 inside Medication Cart D. The LVN 2 stated Resident 11's nitrofurantoin was expired on 12/25/2024, however the night shift staff did not remove this medication from the medication cart. LVN 2 stated she (LVN 2) does not know why this bottle is still present inside Medication Cart D because this antibiotic is being administered at nighttime. LVN 2 stated Resident 11's nitrofurantoin should have been discarded from the medication cart before it was expired and so that the medication would not be accidentally given to Resident 11. LVN 2 stated the potential outcome of administering expired antibiotic to a resident is administering a less effective antibiotic and the inability to treat infection.</p> <p>During an interview on 12/29/2024 at 5:10 p.m., with the DON, the DON stated licensed nurses are required to check the medication cards during every shift and remove and replace the expired medications from the medication cart before the medication expiration date. The DON stated this is important to avoid a medication error of the expired medication accidentally being given to a resident. The DON stated the potential outcome of not disposing an expired antibiotic from medication card is the administration of a less effective antibiotic which would not treat the infection.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility's policy and procedure (P&P) titled, Storage of Medication, dated 1/2023, the P&P indicated outdated, contaminated, discontinued, or deteriorated medications and those in containers that are cracked, soiled, or without secure closure are immediately removed from stock, disposed of according to procedures for medication disposal and reordered from the pharmacy.</p>		

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<p>F 0848</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide a neutral and fair arbitration process and agree to arbitrator and venue.</p> <p>47883</p> <p>Based on interview and record review, the facility failed to provide an Arbitration Agreement (a legal contract that requires parties to resolve disputes through arbitration [a formal method of dispute resolution involving a third party who makes the binding decision] instead of going to court) that included the selection of venue (a location in which to carry out arbitration proceeding) which should be convenient to both parties (resident and facility) to ensure a fair arbitration process to the facility's residents.</p> <p>This deficient practice had a potential to not provide a neutral and fair arbitration process to the facility's residents.</p> <p>Findings:</p> <p>During a review of facility's Arbitration Agreement, the Arbitration Agreement did not include the selection of a venue that is suitable in meeting the needs of both the resident or his or her representative, and the facility.</p> <p>During a concurrent interview and Arbitration Agreement review on 12/29/2024 at 10:12 AM with the Social Service Director (SSD), the SSD reviewed the Arbitration Agreement and confirmed that the Arbitration Agreement did not include the selection of a neutral venue which is suitable in meeting the needs of both the resident or his or her representative and the facility.</p> <p>During an interview on 12/29/2024 at 1:00 PM with the Administrator in Training (AIT), the AIT stated that she was not aware that the Arbitration Agreement must have the selection of venue that is suitable in meeting the needs of both the resident or his or her representative, and the facility.</p>		

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<p>F 0851</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data.</p> <p>47883</p> <p>Based on interview and record review, the facility failed to electronically submit direct care staffing information daily, based on payroll data in the first quarter of 2024.</p> <p>This deficient practice had the potential to not provide the required staffing to ensure residents' care and safety.</p> <p>Findings:</p> <p>During a review of the Certification and Survey Provider Enhanced Report (CASPER) payroll-based Journal (PBJ) Staffing Report, dated 1/1/2024 through 3/31/2024, the CASPER Report indicated that the facility failed to submit data for the first Quarter of 2024.</p> <p>During an interview on 12/29/2024 at 12:51 PM with the Financial Coordinator (FC), the FC stated that she submitted the Staffing Data report [NAME] Report every quarter for the year of 2024. The FC stated that she did not keep the copies of the PBJ Reports. The FC further stated she was receiving electronic confirmation of data submission after the submission of Quarterly Reports. The FC was not able to provide any documentation that indicated the staffing report was submitted for the dates of January 1, 2024, through March 31, 2024.</p> <p>During an interview on 12/29/2024 at 1:11 PM with the Administrator in Training (AIT), the AIT stated that the FC was responsible for submitting the CASPER payroll-based Journal (PBJ) Staffing Report to the Center for Medicare and Medicaid Services (CMS). The AIT was not able to provide to the surveyor a proof of Staffing Reports submitted in 2024 to CMS.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>47883</p> <p>Provide and implement an infection prevention and control program.</p> <p>Based on observation, interview, and record review, the facility failed to implement its policy titled, Sterile Tracheal Suction (a means of clearing the airway of secretions or mucus through the application of negative pressure via suction catheter) by failing to ensure that Respiratory Care Practitioner 2 (RCP 2) doffed (removing gloves in a way that avoids self-contamination [the act of contaminating oneself with potentially pathogenic organism]) nonsterile gloves before the donning (putting on personal protective equipment [PPE] to achieve the intended protection and minimize the risk of exposure) of sterile (free of gems or living organisms, especially microorganisms) gloves when performing a sterile tracheal suction to one (Resident 4) out of five residents investigated during review of the infection control task.</p> <p>This deficient practice had the potential to increase the risk of healthcare acquired infection to Resident 4.</p> <p>Findings:</p> <p>During a review of Resident 4's Admission Record, the Admission Record indicated that the facility initially admitted Resident 4 on 1/15/2018 with diagnoses including encephalopathy (brain disease, damage, or malfunction of brain), acute and chronic respiratory failure with hypoxia (a serious condition that occurs when the air sacs of the lungs cannot release enough oxygen into the blood).</p> <p>During a review of Resident 4's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 1/15/2024, the MDS indicated that the resident had severely impaired cognition (severely damaged mental abilities, including remembering things, making decisions, concentrating, or learning). The MDS further indicated that Resident 4 was totally dependent on staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive).</p> <p>During the review of Resident 4's History and Physical, dated 1/15/2024, the History and Physical indicated that Resident 4 has a tracheostomy (an opening in the neck with inserted tube into the windpipe to help a person breath) in place.</p> <p>During the review of Resident 4's care plan (a document that outlines the actions and interventions needed to address a resident's health and care needs), dated 01/18/2023 and updated 12/06/2024, the care plan indicated that Resident 4 has a tracheostomy related to chronic lung disease (a group of long -lasting conditions that affect the lungs and respiratory system). The care plan interventions indicated to assess the resident every two (2) hours for excessive secretions and suction as necessary.</p> <p>(continued on next page)</p>		

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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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a tracheal suction observation on 12/28/2024 at 3:48 p.m. in Resident 4's room, observed Respiratory Care practitioner 2 (RCP 2) suction Resident 4's tracheostomy. RCP 2 performed hand hygiene (washed hands with soap and water) and applied non-sterile gloves, positioned Resident 4 in semi-Fowlers position (a patient positioning where a person lies on their back with the head of the bed raised 30-45 degrees), listened to Resident 4 lungs, checked oxygen saturation (percentage of oxygen-saturated hemoglobin in the blood), opened the sterile suction kit (included sterile gloves and sterile catheter) and donned sterile gloves over the non-sterile gloves and performed tracheal suction on the Resident 4.</p> <p>During an interview on 12/28/2024 at 3:50 p.m., RCP 2 stated that she (RCP 2) did not know that she had to remove nonsterile gloves before donning the sterile gloves.</p> <p>During an interview on 12/28/2024 at 4:11 p.m. with the Respiratory Department Supervisor (RDS), the RDS stated that according to the facility policy Sterile Tracheal Suction the RCP should have removed non-sterile gloves before applying sterile gloves and providing tracheal suction. The RDS stated not removing nonsterile gloves has the potential to cause increased risk of healthcare acquired infection and pneumonia to Resident 4.</p> <p>During a review of the facility policy named Sterile Tracheal Suction last reviewed on 1/21/2024, the policy stated: Traditional open system sterile suction for non-ventilator residents:</p> <ol style="list-style-type: none"> 1.1 Perform hand hygiene. 1.2 [NAME] nonsterile gloves. 1.3 Identify residents and explain procedure. 1.4 Position resident in semi-Fowlers. 1.5 Doff nonsterile gloves. 1.6 Open sterile suction kit and DON sterile gloves. 1.7 Maintain sterile field: wrap suction catheter around dominant hand . <p>During a review of the facility policy named Hand washing/Hand hygiene, last reviewed on 12/3/2014, the policy stated: This facility will promote appropriate hand hygiene practice to reduce the risk of healthcare acquired infection .".</p>		