STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055443	A. BUILDING _____ B. WING _____	R-C 07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST VALLEY POST ACUTE	7057 SHOUP AVE WEST HILLS, CA 91307

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{F 000}	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during the investigation of a Facility Reported Incident (FRI) Re-visit. Facility Reported Incident Number: CA00902455 The inspection was limited to the specific Facility Reported Incident investigated and does not represent the findings of a full inspection of the facility. Three deficiencies were identified for the Facility Reported Incident: CA00902455 (Refer to Ftag 558, Ftag 656, Ftag 684).	{F 000}	West Valley Post Acute submits this response and Plan of Correction as part of the requirements under State and Federal law. The Plan of Correction is submitted in accordance with specific regulatory requirements; it shall not be construed as admission or agreement of any alleged deficiency cited or any liability. The provider submits this Plan of Correction with the intention that it is inadmissible by any third party in any civil, criminal action or proceedings against the provider of its employees, agents, officers, directors, or shareholders. The provider reserves the right to challenge the cited findings if at any time the provider determines that the disputed findings are relied upon in a manner adverse to the interest of the provider either by the governmental agencies or third party. Any changes to provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the federal rules of evidence and California evidence code section 1151 and should be inadmissible in any proceeding on that basis. For the purposes of any allegation that the facility is not in substantial compliance with federal participation requirements, this response and Plan of Corrections constitutes the facility's allegation of substantial compliance. The facility will be in substantial compliance by 8/6/24	
{F 558} SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure call lights (device used by residents that when pressed informs facility staff that assistance is being requested) were within residents ' reach while in bed for two of three sampled residents (Resident 5 and Resident 6). This deficient practice had the potential to result in a delay with resident care, and residents not receiving assistance with activities of daily living	{F 558}	**F 558** **How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 5 was re-assessed by DON on 7/22/24, call light was observed within reach of resident. Subsequent room rounds performed on resident 5 verified that call light remained in accessible position through discharge date on 7/31/24. Resident 6 was re-assessed by DON on 7/22/24 and 8/5/24. Call lights observed withing reach on both dates.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: F Perez | TITLE: DOM | (X6) DATE: 8/6/24

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.

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{F 558}	Continued From page 1 (ADL- fundamental skills required to independently care for oneself, such as eating, dressing, getting into or out of a bed or chair, taking a bath or shower, and using the toilet). Findings: a. A review of Resident 5's Admission Record indicated the facility originally admitted Resident 5 on 4/25/2021 and readmitted Resident 5 on 5/16/2023 with diagnoses that included Alzheimer ' s disease (progressive disease that destroys memory and other important mental functions), essential hypertension (high blood pressure), unspecified dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), muscle weakness, and limitations of activities due to disability (a person who has a physical or mental impairment that substantially limits one or more major life activity). A review of Resident 5's Minimum Data Set (MDS- a standardized assessment and screening tool) dated 2/1/2024, indicated Resident 5 has severely impaired cognitive (refers to conscious mental activities including thinking, reasoning, understanding, learning, and remembering) skills for daily decision making. The MDS indicated Resident 5 was dependent with eating, oral hygiene, toileting hygiene, lower body dressing and personal hygiene. During an observation on 7/22/2024 at 1:45 p.m., observed Resident 5 in bed inside Resident 5 ' s room with the call light not within reach. Observed Resident 5 ' s call light tucked in between Resident 5 ' s mattress and siderail.	{F 558}	**How the facility will identify other residents having the potential to be affected by the same deficient practice and what action will be taken:** On 7/22/24, RN Supervisor and Maintenance Director performed a facility wide sweep on call light placement. No other residents were found to have been affected. Department Head room rounds performed between 7/23/24-8/5/24 identified no other issues with call lights not being within resident reach. **What measures will be put into place or what systemic changes you will take to ensure that the deficient practice will not recur:** Nursing staff were re-educated on 7/23/24 and 8/5/24 on call light policy and procedure with a focus on call light placement. CNA 3 was given 1:1 counseling on 7/23/24 regarding call light placement and issued disciplinary action on same date. Department Heads will continue to conduct daily room rounds to monitor compliance for 3 months. Administrator or designee will review results of manager room rounds every Monday to Friday. RN Supervisors will perform a daily random inspection on 10 residents per shift for 3 months. Negative findings will be reported to the DON or Designees for immediate corrective actions as necessary. **How the facility plans to monitor its performance to make sure that solutions are sustained.**	

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{F 558}	Continued From page 2 During an observation and concurrent interview with Certified Nursing Assistant 3 (CNA 3) on 7/22/2024 at 1:50 p.m., observed Resident 5 in bed inside Resident 5 ' s room with the call light not within reach. Observed Resident 5 ' s call light tucked in between Resident 5 ' s mattress and siderail. Observed CNA 3 place the call light within Resident 5 ' s reach and stated that it is okay that Resident 5 ' s call light was not within reach because Resident 5 was asleep and did not need it. CNA 3 continued to state that the call light should always be next to the resident. b. A review of Resident 6's Admission Record indicated the facility readmitted Resident 6 on 6/7/2024 with diagnoses that included unspecified dementia, and Alzheimer ' s disease, A review of Resident 6's MDS dated 6/10/2024 indicated Resident 6 has severely impaired cognitive skills for daily decision making. The MDS indicated Resident 6 needed maxium assistance from staff with eating and upper body dressing. The MDS indicated Resident 6 was dependent on staff with oral hygiene, toileting hygiene, shower/bathing, and lower body dressing. During an observation and concurrent interview with CNA 3 on 7/22/2024 at 1:51 p.m., observed Resident 6 in bed with Resident 6 ' s call light under Resident 6 ' s pillow, not within Resident 6 ' s reach. CNA 3 stated that Resident 6 ' s call light is under his (Resident 6) pillow because CNA 3 placed it under Resident 6 ' s pillow when CNA 3 was changing Resident 6. CNA 3 stated that CNA 3 forgot to place Resident 6 ' s call light back within reach. Observed CNA 3 placing the call light within Resident 6 ' s reach. CNA 3 stated	{F 558}	The Administrator and DON will report findings and trends to the QA committee on a monthly basis for three months to ensure that all corrective actions and systemic changes are implemented, sustained, and re-evaluated for effectiveness and for further action planning and/or additional staff training as needed. **Corrective action completion date.** 8/6/24	

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{F 558}	Continued From page 3 that the resident ' s call light should always be within so that a resident can call for assistance when needed. During an interview with the Minimum Data Set Coordinator (MDSC) on 7/22/2024 at 2:32 p.m., the MDSC stated that all residents call lights should always be within residents reach so that resident can call staff for assistance when a resident is in need. A review of the facility provided policy and procedure titled "Answering the Call light", reviewed 6/26/2024, indicated that when the resident is in bed or confined to a chair, the call light is within easy reach of the resident.	{F 558}		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse	F 656	**F 656** **How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 2 had care plan developed for Warafin use on 7/28/24 Resident 7 had care plan developed for Digoxin use on 7/28/24 Resident 8 had care plan developed for Phenytoin use on 7/22/24 No adverse effects were noted from this deficient practice. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what action will be taken:** Current in house residents were reviewed by MDS department on 8/6/24 to insure care plans are reflecting diagnosis and medications used have care plans in place. No other residents were found to have been affected.	

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F 656	Continued From page 4 treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop a comprehensive person-centered care plan (a plan for a resident ' s specific health needs and desired health outcomes) for three of three sampled residents (Resident 2, 7 and 8) by: 1. Failing to ensure a care plan was developed for Resident 2 ' s use of Warfarin (a medication used to treat and prevent blood clots [gel-like clumps of blood]).	F 656	**What measures will be put into place or what systemic changes you will take to ensure that the deficient practice will not recur:** In-service was initiated by DON on 7/24/24 to IDT members and MDS staff regarding policy and procedures on comprehensive care plans and goals and objectives (care plan). Medical Records will audit at least 3 random resident care plans that have been completed within 14 days of admission on a weekly basis to insure care plans are reflecting active diagnosis and medications used. DON or designee will review results from Medical Records random weekly audits weekly for 3 months to determine compliance and insure that no new issues are identified. **How the facility plans to monitor its performance to make sure that solutions are sustained.** DON will report findings and trends to the QA committee on a monthly basis for three months to ensure that all corrective actions and systemic changes are implemented, sustained, and re-evaluated for effectiveness and for further action planning and/or additional staff training as needed. **Corrective action completion date.** 8/6/24	

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F 656	Continued From page 5	F 656		

2. Failing to ensure a care plan was developed for Resident 7 ' s use of Digoxin (medication use to treat congestive heart failure [CHF- A weakened heart condition that causes fluid buildup in the feet, arms, lungs, and other organs]).

3. Failing to ensure a care plan was developed for Resident 8 ' s use of Phenytoin (Dilantin- a medication used to treat seizures [a sudden, uncontrolled burst of electrical activity in the brain which can cause changes in behavior, movements, feelings, and levels of consciousness]).

These deficient practices had the potential to result in failure to deliver necessary care and services for Resident 2, 7 and 8.

Findings:

1. A review of Resident 2 ' s Admission Record indicated the facility readmitted Resident 2 on 7/8/2024 with diagnoses that included infection of amputation (surgical removal of a body part) stump (portion of the leg remaining after an amputation) of the right lower extremity (right leg).

A review of Resident 2's Minimum Data Set (MDS- a standardized assessment and screening tool) dated 6/1/2024, indicated Resident 2 has moderately impaired cognitive (refers to conscious mental activities including thinking, reasoning, understanding, learning, and remembering) skills for daily decision making. The MDS indicated Resident 2 requires partial to moderate assistance with eating and required maximum assistance with oral hygiene, upper body dressing and personal hygiene.

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F 656	Continued From page 6	F 656		

A review of Resident 2 ' s Physician ' s Order indicated an order for Warfarin 6.5 milligrams (mg- unit of measurement) by mouth one time a day for deep vein thrombosis (DVT -when a blood clot forms in a vein deep inside your body) prophylaxis (when a medication is being given to prevent a condition) for three (3) days; with an order date of 7/21/2024.

During an interview and concurrent record review with the Minimum Data Set Coordinator (MDSC) on 7/22/2024 at 3:15 p.m., the MDSC reviewed Resident 2 ' s care plans from 7/21/2024 to 7/22/2024 and stated that Resident 2 did not have a care plan for Resident 2 ' s use of Warfarin. MDSC stated that a care plan should have been developed for Resident 2 ' s use of Warfarin because the care plan guides facility staff on how to provide care to a resident taking Warfarin.

2. A review of Resident 7 ' s Admission Record indicated the facility readmitted Resident 7 on 6/24/2024 with diagnoses that included paroxysmal atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow).

A review of Resident 7's MDS dated 6/27/2024,' indicated Resident 7 has severely impaired cognitive skills for daily decision making. The MDS indicated Resident 7 required moderate assistance with eating and oral hygiene. The MDS further indicated that Resident 7 was dependent on staff with toileting hygiene and lower body dressing.

A review of Resident 7 ' s Physician ' s Order indicated an order for Digoxin Tablet 125

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F 656	Continued From page 7	F 656		

microgram (mcg - unit of measurement) and to give one (1) tablet by mouth one time a day for paroxysmal atrial fibrillation with an order date of 6/25/2024.

During a concurrent interview and record review with MDSC on 7/22/2024 at 3:22 p.m., MDSC reviewed Resident 7 ' s care plans from 6/24/2024 to 7/22/2024. MDSC stated that Resident 7 did not have a care plan developed for Resident 7 ' s use of Digoxin.

3. A review of Resident 8 ' s Admission Record indicated the facility admitted Resident 8 on 7/5/2024 with diagnoses that included epilepsy (disorder in which nerve cell activity in the brain is disturbed, causing seizures).

A review of Resident 8's Minimum Data Set MDS dated 7/8/2024 indicated Resident 8 has moderately impaired cognitive skills for daily decision making. The MDS indicated Resident 8 required moderate assistance with eating, oral hygiene, upper body dressing and personal hygiene. The MDS further indicated that Resident 8 was dependent on staff with toileting hygiene and lower body dressing.

A review of Resident 8 ' s Physician ' s Order date 7/6/2024 indicated an order for Phenytoin Sodium Extended Oral Capsule 300 mg and to give one capsule by mouth at bedtime for seizure disorder.

During a concurrent interview and record review with the MDSC on 7/22/2024 at 3:28 p.m., the MDSC reviewed Resident 8 ' s care plans from 7/5/2024 to 7/22/2024 and stated that Resident 8 did not have a care plan developed for the use of Phenytoin.

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F 656	Continued From page 8 During an interview with the MDSC on 7/22/2024 at 4:00 pm, when asked how come the care plans for Resident 2 ' s warfarin use, Resident 7 ' s digoxin use, and Resident 8 ' s phenytoin use was not done, MDSC stated that the individualized care plan for Resident 2 ' s warfarin use, Resident 7 ' s digoxin use, and Resident 8 ' s phenytoin use were missed and should have been developed. A review of the facility ' s policy and procedure titled "Goals and Objectives, Care Plan", revised 9/2023, indicated care plans shall incorporate goals and objectives that lead to the resident ' s highest obtainable level of independence. Care plan goals and objectives are defined as the desired outcome for a specific resident problem.	F 656		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure laboratory orders were obtained for the use of Phenytoin Sodium (Dilantin- a medication used to treat seizures [a sudden, uncontrolled burst of electrical activity in the brain which can cause changes in behavior,	F 684	**F684** **How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 8 was re-assessed by RN supervisor on 7/22/24 with no change in condition noted. Resident 8's attending physician was contacted on 7/22/24 regarding an order for baseline labs and a new order for baseline labs with Phenytoin level to be drawn on 7/23/24 and Q6 months was obtained and carried out. Phenytoin level results were relayed on 7/23/24 to attending physician, no new orders were issued and no adverse effects noted. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what action will be taken:**	

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F 684	Continued From page 9 movements, feelings and levels of consciousness]) for one of three sampled residents (Resident 8) in order to determine if the dose of the Phenytoin Sodium is within therapeutic drug levels (measures the amount of certain medicines in your blood, to determine if the dose of the medication is within expected range). This deficient practice placed Resident 8 at risk of not receiving appropriate care and services and had the potential to result in having nontherapeutic laboratory levels which may cause seizure activity. Findings: A review of Resident 8 ' s Admission Record indicated the facility admitted Resident 8 on 7/5/2024 with diagnoses that included epilepsy (disorder in which nerve cell activity in the brain is disturbed, causing seizures). A review of Resident 8's Minimum Data Set (MDS- a standardized assessment and screening tool) dated 7/8/2024 indicated Resident 8 has moderately impaired cognitive (refers to conscious mental activities including thinking, reasoning, understanding, learning, and remembering) skills for daily decision making. The MDS indicated Resident 8 required moderate assistance with eating, oral hygiene, shower/bathing, upper body dressing and personal hygiene. The MDS further indicated that Resident 8 was dependent on staff with toileting hygiene and lower body dressing. A review of Resident 8 ' s Physician ' s Order dated 7/6/2024 indicated an order for Phenytoin	F 684	Current in house residents were reviewed by DON and designee on 7/22/24 to insure residents taking medications that require therapeutic levels have baseline order in place. No other residents were found to have been affected. **What measures will be put into place or what systemic changes you will take to ensure that the deficient practice will not recur:** Licensed nurses were in-serviced on 7/23/24 regarding quality of care policy and procedure along with re-education on medications that may require baseline labs to monitor for therapeutic levels. Admission procedures updated to include clarifying with attending physicians if any of the medications ordered require baseline labs while verifying orders upon admission. Pharmacy partner for facility has been contacted and requested to assist in identifying any medications ordered upon admission that could benefit from baseline labs during their initial medication regimen review. Medical records staff will audit newly admitted residents weekly to insure that medications that may require baseline labs to monitor for therapeutic levels have an order in place for baseline labs or declination by the attending physician. DON or designee will review medication audits from medical records along with IMRR from pharmacist for new admissions weekly for 3 months to ensure compliance. **How the facility plans to monitor its performance to make sure that solutions are sustained.**	

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F 684	Continued From page 10 Sodium Extended Oral Capsule 300 milligrams (mg- unit of measure) and to give one capsule by mouth at bedtime for seizure disorder. During a concurrent interview and record review with Minimum Data Set Coordinator (MDSC) on 7/22/2024 at 3:30 p.m., the MDSC reviewed Resident 8 ' s physician ' s orders and stated that Resident 8 has an order for Phenytoin Sodium Extended Oral Capsule 300 Mg for seizure disorder. The MDSC stated that all residents on Phenytoin should be monitored for therapeutic drug levels of Phenytoin. When MDSC was asked if Resident 8 had an order for Phenytoin laboratory levels to determine therapeutic drug levels, MDSC reviewed Resident 8 ' s physician ' s orders from 7/5/2024 to 7/22/2024 and stated that there was no documented evidence that Resident 8 had laboratory levels taken for Phenytoin. MDSC stated that Resident 8 should have had an order for Phenytoin lab levels to be taken to ensure that Resident 8 ' s Phenytoin levels are within therapeutic level to avoid seizure activity. During an interview with the Assistant Director of Nursing (ADON) on 7/22/2024 at 4:55 p.m., the ADON stated that Phenytoin lab orders should be obtained from the physician upon admission of a newly admitted resident. During an interview with the Registered Nurse Supervisor (RNS) on 4/22/2024 at 5:57 p.m., RNS stated that Phenytoin is a medication that needs to be monitored by obtaining therapeutic lab levels to ensure the medication is effective and medication levels remains within therapeutic range.	F 684	DON will report findings and trends to the QA committee on a monthly basis for three months to ensure that all corrective actions and systemic changes are implemented, sustained, and re-evaluated for effectiveness and for further action planning and/or additional staff training as needed. **Corrective action completion date.** 8/6/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055443	A. BUILDING _____ B. WING _____	R-C 07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 684	Continued From page 11	F 684		

A review of the facility ' s policy and procedure titled "Quality of Care", undated, indicated that the facility is required to maintain quality of care to meet certain quality indicators and standards set by federal and state laws which include measures related to resident care... health and safety... and more. Facility has quality improvement programs to continuously monitor and enhance the quality of care provided to residents. This includes but not limited to tracking outcomes, conducting regular assessments, and implementing best practices.