STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056363	A. BUILDING _____ B. WING _____	**03/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GRAND VALLEY HEALTH CARE CENTER	**13524 SHERMAN WAY VAN NUYS, CA 91405**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0558 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents needs were accommodated in a timely manner for four of 47 sampled residents (Resident 64, 178, 179, and 38) as evidenced by: 1. Resident 64, 178, 179, and 38 stated staff took longer than 30 minutes to answer call lights. 2. Resident 64, 178, 179, and 38 stated staff turned off their call light and does not ask the residents of their needs. 3. Resident 178's call light was not within reach. This deficient practice had the potential to result in residents' needs not being addressed in a timely manner. Findings: a. A review of Resident 64's admission record indicated the resident was admitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 64's Physician order [REDACTED]. A review of Resident 64's Minimum Data Set (MDS-a standardized assessment and care screening tool) dated 2/6/2020 indicated the resident with adequate hearing, vision, clear speech, understood others, and made self understood. The MDS indicated resident required extensive assistance with bed mobility, transferring, dressing, toileting, and personal hygiene with physical assistance from nursing staff. The MDS indicated the resident is frequently incontinent of bowel and bladder. A review of Resident 64's Activities of Daily Living Function Care Plan initiated dated 2/12/20 indicated the resident with at risk for further decline in function with goals of meeting resident's needs. Care plan interventions included explain all necessary procedures before rendering care and treatment plans and keeping call light within reach. During an interview on 3/2/20 at 9:22 a.m., Resident 64 stated he has call light issues at night shift. Resident 64 stated he usually calls for to be changed at night. Resident 64 stated it takes a long time for anyone to answer his call light. b. A review of Resident 178's admission record indicated the resident was admitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 178's MDS dated [DATE] indicated the resident is cognitively intact. The MDS indicated resident requires extensive assistance with bed mobility, transferring, ambulation, dressing, toileting, and personal hygiene. During a concurrent observation and interview on 3/2/20 at 10:00 a.m., Resident 178 yelling for help inside room observed Certified Nursing Assistant (CNA 2) picked up call button from the floor and handed it to the resident. Resident 178 stated he wants to be repositioned. Resident stated his call button is always on the floor and have to holler for anyone to answer his call light. Resident 178 stated it takes about 15 minutes for anyone to answer his call light. Resident 178 there is nothing much he can do until someone answers. Resident 178 stated when someone does answer they have to look for another person to help with his care. Resident 178 stated he needs assistance with repositioning and cannot do much by himself. Resident 178 stated during shift change especially at night it takes more than 30 minutes to answer his call light. Resident 178 stated he is here because of his pressure ulcer on the left buttock and have to be repositioned because it is painful, and he needs assistance with turning. c. A review of Resident 179's admission record indicated the resident was admitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 179's Nurses' Admission Record dated 2/28/2020 indicated the resident with two-person assist with transfers and is on bedrest. A review of Resident 179's ADL Function Care Plan dated 2/28/2020 indicated the resident requires extensive assistance from staff with goals of resident's needs will be met promptly included interventions explain all necessary procedures before rendering care and treatment plans and observe resident frequently and anticipate resident's needs and meet them promptly. A review of Resident 179's Physical Therapy and Evaluation Plan of Treatment signed by physician on 3/2/2020 indicated resident requires total dependence with transfers, sitting to stand, and stand pivot. During an interview on 3/2/20 at 9:33 a.m., Resident 179 stated he has issues with call light response from staff and at night it takes about 30 minutes and he needed to be change. Resident 179 stated when the staff does come to answer his call light, they turn it off and tells him that he/she will get somebody to help him or tells him that he/she will be back, but no one comes back. Resident 179 stated he pushes his call light again 15 minutes later and staff come back and turns it off again and still not being assisted. d. A review of Resident 38's admission record indicated the resident was readmitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 38's MDS dated [DATE] indicated the resident with adequate hearing, impaired vision, and clear speech, made self understood, and understood others. The MDS indicated the resident required extensive assistance with bed mobility, transferring, dressing, toileting, personal hygiene, and eating with physical assistance from nursing staff. The MDS indicated resident occasionally incontinent of bowel and bladder. A review of Resident 38's ADL Function Care Plan re-evaluated date 1/16/2020 indicated the resident requires assistance from staff with goals of resident's needs will be met promptly daily. The care plan interventions included keeping call light within easy reach, frequently check on resident, anticipate resident's needs, and to meet them promptly. During an interview on 3/2/20 at 10:27 a.m., Resident 38 stated he needs assistance with his care and takes about 30-45 minutes for anyone to assist him. Resident 38 stated there is issue with response time and manner when somebody comes in and turns off the call light and tells him they have to find somebody to help him, but they forget and has to call again for assistance. During an interview on 3/5/20 at 2:59 p.m., the Director of Nursing (DON) stated call lights should be answered by staff within 3-5 minutes. DON stated staff are instructed to leave the lights on so the staff who answered the call light is aware that the resident still needs help. DON stated that in the past she has noticed that if the call light was turned off and the staff gets distracted tend to forget that the resident still needs assistance. DON stated the purpose of having the call light within easy reach so that it is easily accessible for all residents. A review of the facility's policy and procedure titled Call Lights reviewed and approved 7/9/19 indicated that it is the policy of the facility to respond to the resident's requests and needs. When the resident is in bed or in the wheelchair or chair in the room, staff should make sure that the call light is within easy reach of the resident. Call lights should be answered promptly. If the staff need to leave the room to fulfill the resident's request, they should return promptly.
F 0584 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** Based on interview and record review, the facility failed to maintain a comfortable noise level for two of eight resident group meeting attendees. This deficient practice has the potential negatively affect the resident's quality of life. Findings: During resident group meeting interview on 3/2/20 at 2:15 p.m., two of eight resident attendees stated noise levels during shift changes is loud and have to keep their door closed. Residents stated it is good for a month or two and then noise is loud back to it again. During an interview on 3/5/20 at 2:50 p.m., the Director of Nursing (DON) stated noise levels were addressed in the resident council minutes regarding the staff being noisy during the 11 p.m. to 7 a.m. shift. DON stated in-service was provided to the night shift. A review of the Resident Council (an organized group of nursing home residents that meets on a regular basis to discuss concerns, suggest changes the residents would like, and identify and plan for desired social activities) Minutes (transcript) dated 1/13/2020 indicated that three residents stated that noise level is loud at night shift (11 p.m. to 7 a.m.). A review of the In-Service (training) Minutes dated 1/23/2020 indicated

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

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 0584 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) topic discussed Noise Level indicated the summary of lecture the importance of lowering the noise level at night, use lower volume of voice, no yelling across hallways, and when speaking to a coworker be careful of voice level.
F 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure intravenous therapy care plan was developed for one of three residents (Resident 180) investigated under the hospitalization care area who was admitted with a peripherally inserted central catheter (PICC-a type of long catheter that is inserted through a peripheral vein, often in the arm, into a larger vein in the body, used when intravenous (IV-through the vein) treatment is required over a long period) line and receiving IV antibiotics. This deficient practice had the potential to result in central line access not being monitored and places the resident for potential complications such as infection and bleeding. Findings: A review of Resident 180's admission record indicated the resident was admitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 180's nurses' admission assessment dated [DATE] indicated the resident with peripherally inserted central catheter (PICC-a type of long catheter that is inserted through a peripheral vein, often in the arm, into a larger vein in the body, used when intravenous treatment is required over a long period) line single lumen on the right arm. A review of Resident 180's Physician order [REDACTED]. - Dressing change every weekly. A review of Resident 180's Minimum Data Set (MDS-a standardized assessment and care screening tool) dated 2/27/2020 indicated the resident with severely impaired cognitive skills (the core skills the brain used to think, read, learn, remember, reason, and pay attention) for daily decision making. During a concurrent interview and record review of Resident 180's care plans on 3/4/20 at 9:08 a.m., the Minimum Data Set nurse (MDS) confirmed the resident did not have documented evidence of initiation of an IV therapy care plan. During an interview on 3/5/20 at 3:14 p.m., the Director of Nursing (DON) stated the residents with IV therapy care plan to make sure providing the necessary care necessary related medication and site and monitoring side effects. DON stated the baseline care plan should be developed within 24 hours and nursing-related should be indicated with the baseline care plan if anything pertaining to admission. A review of the facility's policy titled Comprehensive Care Planning reviewed and approved on 7/9/2019 indicated that it is the policy of this facility that a comprehensive care plan be developed for each resident. A baseline care plan with minimum healthcare information will be developed and implemented within 48 hours of admission. The baseline care plan will address effective and resident centered care that meets professional standards for quality of care.
F 0690 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to provide peri-care (washing the genitals and anal area and this can be done during a bath or as a separate procedure) for one of one resident (Resident 15) investigated under the bowel and bladder care area who is at risk for moisture associated skin damage (MASD-inflammation and erosion of the skin caused by prolonged exposure to various sources of moisture, including urine/stool, perspiration, exudate, mucus, and saliva). These deficient practices placed the resident at risk for urinary tract infection (UTI- infection that affects part of the urinary tract-kidneys, ureters, urinary bladder and the urethra), skin breakdown and exposure to foul order. Findings: A review of Resident 15's admission record indicated the resident was admitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 15's Minimum Data Set (MDS-a standardized assessment and care screening tool) dated 12/10/19 indicated the resident with adequate hearing and vision, no speech, rarely or never understood and rarely or never understood others. The MDS indicated resident's cognitive skills (the core skills the brain used to think, read, learn, remember, reason, and pay attention) for daily decision making is severely impaired. The MDS indicated resident required total dependence with toileting and personal hygiene and always incontinent of bowel and bladder. A review of Resident 15's Incontinence of B&B re-evaluated date 12/12/19 indicated the resident with incontinent of both bowel and bladder with goals of free from any skin breakdown due to incontinence. The interventions included to provide proper peri-care after each incontinence - may use peri-wipes for incontinent care. During an observation on 3/5/20 at 9:27 a.m., the Licensed Vocational Nurse (LVN 3) provided wound treatment to Resident 15's sacrococcyx (tail bone) assisted by Certified Nursing Assistant (CNA 1). LVN 3 applied duoderm dressing (impermeable to water vapor, oxygen and bacteria) on site. LVN 3 stated resident is voiding and needs to be changed. CNA 1 removed soiled brief and soiled linen sheet and put on clean briefs. No perineal care was observed. On 3/5/20 at 9:50 a.m., CNA 1 stated she is done with care for Resident 15. CNA 1 stated she gave resident bed bath earlier before wound treatment was done. During an interview on 3/5/20 at 1:59 p.m., CNA 1 stated today was Resident 15's shower day and provided around 9 a.m. before wound treatment. CNA 1 stated she will check around 2 p.m. and every 2 hours every time she repositions resident. CNA 1 stated she checked around 9:30 a.m. and resident was dry and will check now if needed to be changed. CNA 1 stated the sheet and briefs were soiled and needed to be changed. CNA 1 stated when resident had incontinence episode after shower, she uses wipes to clean. CNA 1 stated there were no wipes available and resident's family brings those in. CNA 1 stated if no wipes then can use wash cloths with soap and water. CNA 1 stated she should have provided the incontinence care when resident's brief was changed. CNA 1 stated it is important to provide incontinence care after each incontinent episode because resident has risk for rashes and redness. CNA 1 stated she is aware resident had moisture skin damage that turned into pressure ulcer. CNA 1 stated resident can have more moisture skin damage if incontinence care was not provided. During an interview on 3/5/20 at 3:10 p.m., the Director of Nursing (DON) stated incontinence care should be provided anytime resident has episode of incontinence. DON stated the purpose of providing incontinence care is for cleanliness, to protect resident's skin, and dignity. A review of the facility's policy and procedure titled Perineal Care reviewed and approved on 7/9/19 indicated the purpose of this procedure is to provide cleanliness and comfort to the resident, to prevent infection and skin irritation, and to observe the resident's skin condition.
F 0698 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Past noncompliance - remedy proposed** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that a resident who was receiving [MEDICAL TREATMENT] (clinical purification of blood as a substitute for the normal function of the kidney) treatment received services consistent with professional standards of practice for one of one resident (Resident 178) investigated under the [MEDICAL TREATMENT] care area, by: 1. Failing to ensure emergency [MEDICAL TREATMENT] kit is available at Resident 178's bedside as ordered. 2. Failing to clarify physician order for [REDACTED]. Findings: A review of Resident 178's admission record indicated the resident was admitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 178's physician order indicated the following order ordered on [DATE]: - [MEDICAL TREATMENT] every Tuesday, Thursday, and Saturday - Monitor availability of emergency pressure dressing kit bedside every shift A review of Resident 178's Minimum Data Set (MDS-a standardized assessment and care screening tool) dated 3/3/2020 indicated the resident is cognitively intact. The MDS indicated resident requires extensive assistance with bed mobility, transferring, ambulation, dressing, toileting, and personal hygiene. During a concurrent observation and interview on 3/2/20 at 10:00 a.m., Resident 178 stated he receives [MEDICAL TREATMENT] treatment and last one he had was Saturday and will have another one tomorrow. Resident 178 stated he has a left arm AV shunt (surgical joining of an artery and a vein under the skin to create a [MEDICAL TREATMENT] (blood purifying treatment) access port) for [MEDICAL TREATMENT]. There was no [MEDICAL TREATMENT] kit noted inside the resident's room. During a concurrent observation and interview on 3/3/20 at 7:23 a.m., the Licensed Vocational Nurse (LVN 1) confirmed at Resident 178's bedside there was no emergency [MEDICAL TREATMENT] kit noted at bedside. LVN 1 stated there should be a [MEDICAL TREATMENT] kit at the bedside for residents who are receiving [MEDICAL TREATMENT] treatments. LVN 1 stated she does not know why there is not one. LVN 1 stated the Central Supply staff will place the [MEDICAL TREATMENT] kit at the bedside. During a concurrent interview and record review of Resident 178's clinical record on 3/4/20 at 8:25 a.m., the Minimum Data Set nurse (MDS) confirmed the following: - [MEDICAL TREATMENT] Care Plan MDS confirmed there was documentation for monitoring for available dressing kit resident's bedside. - MDS confirmed the Licensed Nurses Progress notes indicated on the 2/26/20 on Wednesday Resident 178 received an extra [MEDICAL TREATMENT] treatment. MDS stated she will ask the Assistant Director of Nursing (ADON) and find out for the HD that was

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F 0698 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) done on 2/26/20 because she does not see an order for [REDACTED]. ADON stated the registered nurse (RN) assigned should have notified the physician why the resident is leaving the building. During an interview on 3/5/20 at 3:04 p.m., the Director of Nursing (DON) stated there was a verbal endorsement for Resident 178 and was communicated and went to [MEDICAL TREATMENT] with no physician's order and there should have been an extra order. DON stated there should be an order potential for missed [MEDICAL TREATMENT] treatment. During a concurrent interview and record review of the facility's [MEDICAL TREATMENT] Care policy on 3/05/20 at 3:07 p.m., DON confirmed there is no documentation in their policy about providing the emergency kit. DON stated the licensed nurses are responsible for checking [MEDICAL TREATMENT] kit is available at the bedside the supply office does a visual check. DON stated during the huddle the RN supervisor makes a note under special needs list and to provide copies to the licensed nurses. DON stated the emergency kit should be provided as soon as resident is admitted and readily available in case of emergency such as bleeding pressure dressing is immediately applied. A review of the facility's policy and procedure titled [MEDICAL TREATMENT] Care reviewed and approved on 7/9/2019 indicated it is the policy of the facility to provide standards for the resident receiving shunt care.
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** Based on observation, interview, and record review, the facility failed to ensure two licensed nurses reconciled the Narcotic Key Control Record (accountability record of medications that are considered to have strong potential for abuse) accurately for two out of three medication carts (Medication Cart #2 and Medication Cart #3) reviewed during Medication Storage and Labeling facility task. This deficient practice resulted in inaccurate reconciliation of the controlled medications and placed the facility at potential for inability to readily identify loss and drug diversion (illegal distribution or abuse of prescription drugs or their use for unintended purposes) of controlled medications. Findings: During an inspection of Medication Cart #3 and concurrent interview with Licensed Vocational Nurse 1 (LVN 1) on 3/3/20 at 1:20 PM, LVN 1 verified that there were missing signatures on the Narcotic Key Control Record. LVN 1 verified there were missing signatures for Medication Cart #3 on 2/27/20, 3/2/20 and 3/3/20. LVN 1 stated the importance of the Narcotic Key Control Record is to make sure narcotic count is accurate and to show the accountability of counting. During a concurrent interview and record review on 3/3/20 at 3:06 PM, the Director of Nursing (DON) verified there were missing signatures on the Narcotic Key Control Record for Medication Cart #2 on 2/16/20, 2/17/20, 2/27/20, 2/28/20, and 3/3/20. The DON stated the charge nurses from outgoing and incoming shifts usually count the narcotics and sign the Narcotic Key Control Record. The DON stated the medical record department then audits the record for accuracy of documentation on a daily basis. The DON also stated the purpose of counting narcotics during shift change is to make sure the accuracy of number of narcotic medications in each cart and to ensure the accountability. The DON stated the missing signatures in the record indicate the narcotics were not counted. The DON further stated the charge nurses should have counted the narcotics every day and signed it appropriately. A review of the facility's policy and procedures titled, Controlled Medication Storage, dated 8/2014, indicated, A controlled medication accountability record is prepared by the pharmacy or the facility for all Scheduled II-V medications. At each shift change, a physical inventory of all controlled medications, including the emergency supply is conducted by two licensed nurses and is documented on the controlled medication accountability record.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents' medications were kept in a locked cart inaccessible by residents and visitors for one of three residents (Resident 329) observed during Medication Administration. This deficient practice had the potential for residents, visitors, and unauthorized staff having access to the medication and placed residents at risk of ingesting unnecessary medication. Findings: A review of Resident 329's Face Sheet (admission record) indicated the resident was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Resident 329's Minimum Data Set (MDS - a standardized assessment and screening tool), dated [DATE], indicated the resident has the ability to make self understood and has the ability to usually understand others. A review of Resident 329's Self Administration of Medications, dated 2/17/20, indicated the resident is not a candidate for safe self-administration of medications after the Interdisciplinary Team (IDT - group of healthcare providers from different fields who work best outcome for a patient) has evaluated the resident. During a concurrent medication administration observation and interview on 3/3/20 at 8:30 AM, observed one medication bottle labeled [MEDICATION NAME] (medication used in adults to treat neuropathic pain (nerve pain)) 300 milligrams (mg-unit of measurement) on Resident 329's bed. Label indicated, [MEDICATION NAME] 300mg 1 capsule twice a day with a count of 180 from outside pharmacy. Resident 329 stated her son brought the medication and she did not take any medications. During a concurrent observation and interview on 3/3/20 at 8:45 AM, Licensed Vocational Nurse 2 (LVN 2) counted the medications in the bottle and confirmed the count was 172. On further observation it was noted [MEDICATION NAME] cream (medication is used to treat a variety of skin diseases) 0.05%, [MED] ointment (medication to treat superficial skin infections) 2%, Triple antibiotic Ointment (ointment with multiple antibiotics (treat infections caused by bacteria)) and [MEDICATION NAME] +pain relief ointment (ointment with two actions and provides 24-hour infection protection and pain relief) also at Resident 329's bedside. LVN 2 stated the resident should not keep any medications at bedside. During a concurrent interview and record review on 3/3/20 at 2:54 PM, the Director of Nursing (DON) confirmed Resident 329 was not a candidate for safe self-administration of medications. The DON stated the facility usually determines the cognitive (mental action or process of acquiring knowledge and understanding) ability of a resident during initial assessment. The DON stated if the IDT agree for self- administration, the physician has to provide a written order to proceed. The DON further stated the purpose of this process is for the safety of the resident and to track the accuracy of medication. The DON stated [MEDICATION NAME] had a potential to cause an adverse reaction to the resident if ingested with other medications and is contraindicated to the resident. A review of the facility's policy and procedures titled, Medication Storage in the Facility, dated 4/2008, indicated, Bedside medication storage is permitted for residents who are able to self-administer medications, upon the written order of the prescriber and when it is deemed appropriate in the judgement of the facility's interdisciplinary team. A review of the facility's policy and procedures titled, Medication - Self Administration, dated 1/2017, indicated, On admission or shortly thereafter , each resident will be assessed to determine if they want to self- administer their medications. It is the responsibility of the IDT to determine if it is for the resident to self-administer drugs before the resident may exercise that right. The resident will be assessed quarterly to determine their ability to continue to self-administer their medications.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation, interview, and record review, the facility failed to served ice from the ice machine in a sanitary manner for 87 of 87 current in-house residents in the facility by: 1. Failure to maintain ice machine with no debris and discolored water stain. 2. Failure to ensure ice machine was checked and logged according to facility's policy. This deficient practice placed the residents at risk for contamination (presence of potentially harmful substances, including, but not limited to microorganisms, chemicals, or physical objects in food) when drinking from the ice. Findings: During a concurrent observation, interview, and record review on 3/2/20 at 7:39 a.m., the Dietary Services Supervisor (DSS) stated the ice machine is in another location and housekeeping is in-charge of checking the ice machine. DSS confirmed the ice machine cleaning log with missing signatures on 2/29/2020 and [DATE]. Upon swipe inside of the ice machine, DSS confirmed debris noted on paper towel with discolored water stain. DSS stated there should be no debris because it is water and residents drink from this. During an interview on 3/3/20 at 3:11 p.m., the Housekeeping Supervisor (HS) stated he was

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F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) in-charged for both refrigerators. HS stated he was in a hurry past of couple of days and checking temperatures and that he made a mistake. HS he will bring to Administrator's attention and may be more thorough with checking temperature and cleanliness. HS stated the purpose is for the refrigerator and ice machine in clean condition. HS agreed that if left uncleaned there is potential for foodborne illness residents might contract. During an interview on 3/3/20 at 3:28 p.m., the Maintenance Supervisor stated he is in-charged of cleaning the inside of the ice machine, once a month and check daily. MS stated ice machine has to be cleaned should not have any debris because it contains bacteria and the resident's that use it may get sick for drinking dirty water. MS stated the ice machine are used by residents.
F 0813 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Have a policy regarding use and storage of foods brought to residents by family and other visitors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to monitor the residents' foods brought in the facility and stored inside one of one facility residents' refrigerator used for storing 87 of 87 residents' food. This deficient practice had the potential to result in food contamination and food-borne illnesses (infection or irritation of the gastrointestinal tract caused by food or beverages that contain harmful bacteria, parasites, viruses, or chemicals; symptoms include vomiting, diarrhea, abdominal pain, fever, and chills) and can lead to serious medical complications [REDACTED]. DSS confirmed the following inside the resident's refrigerator: 1. Boost choco 240 milliliters (mL) x3 with expiration date 2/27/21 and no name label. 2. Inside a white plastic, DSS stated what looks like a taco with a moldy like particle. DSS should not be there and should be disposed. 3. Noyan sour cherry 16 ounces (oz) with no name and no date when it was opened. DSS confirmed the container is opened with exp date 2/18/21. 4. One plastic container with soup inside with no name and label. 5. One plastic container with no date with liquid inside the container. 6.Two Open Nature Greek yogurt 5.3 oz dated 8/22/19 and 8/21/19. 7. One plastic container (8 cup size), with liquid inside no name and no label. 8. Haagen Daz 14 fluid oz labeled for Resident 36. DSS stated there is a mold like particles inside. DSS stated she will throw away. During an interview on 3/3/20 at 3:11 p.m., the Housekeeping Supervisor (HS) stated he was in-charged for resident's refrigerators. HS stated he was in a hurry past of couple of days and did not check the food and that he made a mistake. A review of the facility's policy and procedure titled Food for Residents from Outside Sources reviewed and approved on 7/9/19 indicated the food brought in from outside the facility kitchen for resident's consumption will be monitored. Procedure: Prepared food brought in for the resident must be consumed within one (1) hour of receiving it to prevent food borne illness. Unused food will be disposed immediately thereafter. Prepared foods, beverages, or perishable food that requires refrigeration, can be stored for the resident in the facility kitchen nursing station's refrigerator or in the residents' personal refrigerator. In the food service department, the policy on food storage will apply. Otherwise, if unopened, refrigerated or frozen items will be disposed of by the expiration date on the container. If opened, the food must be sealed, dated to the date opened and disposed of in 2 days after opening. Frozen items, such as ice cream will be disposed of in 30 days.
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain accurate medical records by failing to accurately document the presence of bruising or unusual bleeding for the use of [MEDICATION NAME] (medication helps to prevent the formation of blood clots) for one of nine residents (Resident 378) investigated under the care area of Unnecessary Medications. This deficient practice had the potential to result in confusion in the delivery of care and services rendered and may lead to inadequate management of Resident 378's anticoagulation (blood thinners) therapy for [MEDICAL CONDITION] (irregular heartbeat that can interrupt the normal flow of blood). Finding: A review of Resident 378's Face Sheet (admission record) indicated the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 378's History and Physical (H&P - the initial clinical evaluation and examination of the patient), dated [DATE], indicated no cognitive (mental action or process of acquiring knowledge and understanding) decline. The H&P also indicated the resident has the capacity to understand and make decisions. A review of Resident 378's Physician order [REDACTED]. - Monitor for bruising and signs and symptoms of unusual bleeding every shift; morning, evening, and night, secondary to [MEDICATION NAME] use. 0 = None, 1 = Bleeding gums, 3 = Blood in urine, 4 = Dark stool, 5 = Bloody emesis, 6 = Bruising, 7 = Other. During a concurrent interview and record review on 3/4/20 at 2:45 PM, the Minimum Data Set (MDS - a standardized assessment and screening tool) Coordinator verified that the Monitoring Administration History indicated that the licensed nurses documented with their initials and X marks instead of numbers from 0 to 7 to show the signs and symptoms of bleeding. The MDS Coordinator confirmed there was no appropriate documentation for monitoring signs and symptoms of unusual bleeding. The MDS coordinator stated the licensed nurses should have used the numbers to indicate the accurate documentation. She also stated the importance for monitoring the signs of unusual bleeding is to identify any complications related to the use of medication and inform the physician timely. During an interview on 3/4/20 at 3:15 PM, the Director of Nursing (DON) stated the licensed nurses should have used the numbers from 0 to 7 to indicate the accurate monitoring and inform the physician if any signs of unusual bleeding occur. The DON also stated the importance of monitoring bleeding is to know any complications related to the use of [MEDICATION NAME] and report to the physician at appropriate times. A review of the facility's policies and procedures titled Health Information Record Manual, dated 2/11/2019, indicated to record applicable observations, psychosocial and physical manifestations, incidents, unusual occurrences, and abnormal behavior. Promptly record as the events or observations occur; complete, concise, descriptive, factual, and accurately describe services provided to/or the resident. Accurately document time of admission, discharge, transfer, and arrival at another area of the facility if applicable, i.e., Rehabilitation Therapy Center; medication/treatments, observations during treatments, and result of treatments.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program by failing to ensure proper hand-washing while assisting with feeding for one out of five residents (Residents 12) during dining observation. This deficient practice had the potential for cross contamination (unintentional transfer of bacteria/germs or other contaminants from one surface to another) among residents. Findings: A review of Resident 12's Face Sheet (admission record) indicated the resident was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. skills). A review of Resident 12's Minimum Data Set (MDS - a standardized assessment and screening tool), dated 1[DATE]19, indicated the resident has the ability to make self understood and has the ability to usually understand others. The MDS also indicated Resident 12 needed one-person physical assist with eating. During a dining observation, on 3/3/2020 at 12:31 PM, observed Restorative Nursing Aide 1 (RNA1) assisting Resident 12 with feeding. RNA 1 picked up a plastic wrap which was on the floor and touched the floor. Then she resumed assisting Resident 12 with feeding. Did not observe RNA 1 perform handwashing before assisting the resident. During an interview, on 3/3/2020 at 01:11 PM, RNA 1 stated she unknowingly picked up the plastic wrap from the floor. She also stated she forgot to wash hands before resuming feeding. She stated she should have washed hands after picking the plastic wrap from the floor. She further stated the importance of handwashing was to prevent infection. During an interview, on 3/5/2020 at 01:11 PM, the Director of Nursing (DON) stated the RNA 1 should have washed hands after picking the plastic wrap from the floor. The DON also stated hand washing is important to prevent transmission of infection to the resident and is a universal precaution to prevent cross contamination. A review of the facility's policies and procedures titled Handwashing/Hand Hygiene, dated 10/2017, indicated all staff members wash their hands before and after direct resident care and after contact with potentially contaminated substances to prevent, to the extent possible, the spread of infection. Handwashing will be performed by staff members after touching inanimate sources that are likely to be contaminated with virulent or epidemiologically important microorganisms.
F 0883 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement policies and procedures for flu and pneumonia vaccinations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056363	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GRAND VALLEY HEALTH CARE CENTER	13524 SHERMAN WAY VAN NUYS, CA 91405

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

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F 0883 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) Based on interview and record review, the facility failed to offer a pneumococcal vaccine (substance used to stimulate the resistance against pneumonia (lung infection)) for one of five residents (Resident 6) reviewed during the facility task Infection Control. This deficient practice had the potential to result in an increased risk of Resident 6 developing pneumonia and can lead to the spread of pneumonia in the facility. Findings: A review of Resident 6's Face Sheet (admission record) indicated the resident was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Resident 6's Minimum Data Set (MDS - a standardized assessment and screening tool) dated 3/3/20, indicated the resident has the ability to sometimes make self understood and has the ability to sometimes understand others. During a concurrent interview and record review on 3/5/20 at 2:04 PM, the Infection Control Preventionist (ICP) verified that Resident 6's Immunization Record indicated the resident received the pneumococcal vaccine on 11/2013, two years before they were admitted to the facility. The ICP verified that there was no documented evidence showing that Resident 6 or their representative was educated or offered the pneumococcal vaccine timely. The ICP stated the resident should have been reevaluated for the need to be administered the pneumococcal vaccine either in the year 2017 or 2018. The ICP also stated Resident 6's immunization status should have been checked and updated during the quarterly MDS meeting. She further stated the importance of the pneumonia vaccine is to prevent pneumonia especially for residents above the age of 65 because of their weak immune system and medical condition. A review of the facility's policy and procedure titled, Pneumonia Vaccine, dated 1/2017, indicated, On admission, all residents will be evaluated for pneumococcal vaccination needs. Each resident will be offered a pneumococcal immunization, unless the immunization is medially contraindicated or the resident has already been immunized. The resident's clinical record should include documentation that the resident or their representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and that the resident either received the immunization or did not receive the immunization due to medical contraindications or refusal.
F 0912 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	**Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms.** Based on observation, interview, and record review, the facility failed to provide at least 80 square feet (sq. ft. - unit of measurement) per resident in multiple resident bedrooms for the four out of the 89 resident rooms. The four rooms consisted of two beds each. This deficient practice had the potential to result in inadequate useable living space for all the residents and working space for the healthcare caregivers. Findings: The Request for Room Size Waiver letter dated 3/2/20, submitted by the Administrator for the four rooms was reviewed. The letter indicated the rooms did not meet the 80 square feet requirement per federal regulation. The letter indicated there are no projections or obstructions which may interfere with free movement of wheelchairs and/or sitting devices. The letter also indicated there is enough space to provide for each resident's care, dignity and privacy and that the rooms are in accordance with the special needs of the residents. The letter indicated the spaces would not have an adverse effect on the residents' health and safety or impede the ability of any resident in the rooms to attain his or her highest practicable well-being. The following rooms provided less than 80 square feet per resident: Rooms # Beds Floor Area Sq. Ft. Sq. Ft/Resident 1 2 146 73 3 2 155 77.5 9 2 143 71.5 11 2 151 75.5 The minimum square footage for a 2-bed room should be 160 sq. ft. During interviews with staff Certified Nursing Assistant 3 and 4 (CNA 3, CNA 4 and CNA 5), Licensed Vocational Nurse 2 and 4 (LVN 2 and LVN 4) on 3/3/20 at 10:45 AM, there were no concerns regarding the size of the rooms. During the Resident Council meeting, on 3/3/20 at 10:45 AM, no concerns were brought up by the residents regarding the size of the rooms. During the general observation of the residents' rooms on 3/3/20, the residents had ample space to move freely inside the rooms. There were sufficient spaces to provide freedom of movement for the residents and for nursing staff to provide care to the residents. There were also sufficient space for beds, side tables and resident care equipment. The facility submitted a written request for continued waiver.
F 0921 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.** Based on observation, interview and record review, the facility failed to ensure 87 of 87 current in-house residents were provided safe and secure environment by failing to ensure back door entrance was not accessible to visitors. This deficient practice had the potential to result in unauthorized persons entering the facility and the potential to negatively impact the psychosocial wellbeing of the residents. Findings: On 3/2/20 at 7:10 a.m., seven surveyors entered the facility through the back door next to the kitchen. Left unlocked and no alarm sound or lights went off. During an interview on 3/5/20 at 4:22 p.m., the Administrator (ADM) stated that house rules is at 10 a.m. to 8 p.m. and may extend depending on the resident's condition and if family wants to stay over and with his approval. ADM stated the house rules was started effective July 2019 and only the back door is open from 7 a.m. to 8:30 a.m. and have to use the doorbell to get in from the back. ADM stated visitors must enter from the front and sign-in. A review of the facility's policy titled Facility Guidelines reviewed and approved 7/9/2019 indicated that the facility is locked at 8 p.m. to protect the security of all the facility's residents, if visitors are planning to arrive after 8 p.m.