

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555012	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/30/2024
NAME OF PROVIDER OR SUPPLIER  Valley Village Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  13000 Victory Blvd North Hollywood, CA 91606	

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 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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46445</b></p> <p>Based on observation, interview, and record review, the facility failed to provide necessary respiratory care and services for two of four sampled residents (Resident 2 and Resident 3) by failing to:</p> <ol style="list-style-type: none"> <li>1. Ensure Resident 2 and Resident 3's oxygen tubings were dated when it was changed.</li> <li>2. Ensure Resident 2's oxygen tubing was free from kinks.</li> </ol> <p>These deficient practices had the potential for the residents to receive less oxygen needed in the body and develop respiratory diseases or infections.</p> <p>Findings:</p> <p>a. A review of Resident 2's Admission Record indicated the facility admitted the resident on 4/4/2024 with diagnoses that included interstitial pulmonary disease (a large group of diseases that cause scarring of the lungs), dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), and essential hypertension (an abnormally high blood pressure that was not a result of a medical condition).</p> <p>A review of Resident 2's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 4/11/2024, indicated the resident's cognitive (mental action or process of acquiring knowledge and understanding) skills was severely impaired.</p> <p>A review of the Physician Orders, dated 4/4/2024, indicated an order to administer oxygen at two to five liters per minute via nasal cannula (is a device that delivers extra oxygen through a tube and into your nose continuously) to maintain oxygen saturation (measures how much oxygen is carried by the hemoglobin [a protein in red blood cells that carries oxygen] in your blood) above 90 percent (%-unit of measurement) as needed for shortness of breath.</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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/30/2024 at 10:22 a.m., during a concurrent observation and interview with Registered nurse 1 (RN 1), Resident 2's oxygen cannula was observed on the resident's chest under the blanket. RN 1 stated that Resident 2's nasal cannula should be on the resident's nose. Resident 2's oxygen tubing connecting the oxygen concentrator (a medical device that separates nitrogen from the air so a person can breathe up to 95% pure oxygen) to the humidifier (a device that release water vapor or steam) was observed to be kinked. RN 1 stated that a kinked oxygen tubing had the potential for Resident 2 to receive less than required oxygen. Resident 2's oxygen tubing and oxygen cannula were not labeled with the date the supplies were replaced. Resident 2 did not have an oxygen supplies bag at bedside. RN 1 stated that Resident 2's oxygen tubing and cannula should be dated and there should be a dated oxygen supplies bag at bedside. RN 1 stated Resident 2's undated oxygen supplies had the potential to cause infections. RN 1 stated the facility failed to ensure that oxygen supplies were changed and dated.</p> <p>On 5/30/2024 at 1:28 p.m., during a concurrent interview and record review, the facility's policy and procedure titled, Oxygen Administration and Storage, dated 1/2024, was reviewed with the Director of Nursing (DON). The DON stated the facility policy indicated all oxygen or respiratory supplies will be replaced every 7 days and as needed. The Steps in the Procedure section of the policy indicated to check the tubing connected to the oxygen cylinder to assure it is free of kinks. The DON stated the facility failed to label the oxygen supplies and tubing with the date they were replaced. The DON stated the facility failed to ensure Resident 2's oxygen tubing was free from kinks.</p> <p>b. A review of Resident 3's Admission Record indicated the facility admitted the resident on 5/23/2024 with diagnoses that included pulmonary embolism (a blood clot that develops in a blood vessel in the body then travels to a lung artery blocking the blood flow) with acute cor pulmonale (a condition that causes the right side of the heart to fail), respiratory failure (a condition in which the blood does not have enough oxygen or too much carbon dioxide) unspecified with hypoxia (low levels of oxygen in your body tissues), and pulmonary hypertension (occurs when the blood pressure in the lungs is higher than normal).</p> <p>A review of Resident 3's MDS, dated [DATE], indicated the resident's cognitive skills was intact.</p> <p>A review of the Physician Orders, dated 5/27/2024, indicated an order to administer oxygen at one to two liters per minute via nasal cannula continuously to maintain oxygen saturation greater than 82 percent related to respiratory failure unspecified with hypoxia.</p> <p>On 5/30/2024 at 10:30 a.m., during a concurrent observation and interview with RN 1, Resident 3's oxygen tubing was observed undated. RN 1 stated that if the oxygen supply bag was dated, it indicated the tubing was also changed on the same date. RN 1 was not able to state the facility's policy on care of resident's with oxygen.</p> <p>On 5/30/2024 at 1:28 p.m., during a concurrent interview and record review, the facility's policy and procedure titled, Oxygen Administration and Storage, dated 1/2024, was reviewed with the Director of Nursing (DON). The DON stated the facility policy indicated all oxygen or respiratory supplies will be replaced every 7 days and as needed. The DON stated the facility failed to label the oxygen supplies and tubing with the date they were replaced.</p>		