

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  08/19/2024
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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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>42311</p> <p>Based on interview and record review, the facility failed to develop and implement a care plan a person-centered care plan with measurable objectives and timeframes to one out of three sampled residents (Resident 1) by failing to develop a care plan that addressed Resident 4's non compliance with the diet ordered by the physician. Resident 1 was ordering and buying food outside of the facility.</p> <p>This deficient practice had the potential to negatively impact Resident 4's over all health.</p> <p>Findings:</p> <p>During a record review of Resident 1 ' s Admission Record, it indicated the facility admitted Resident 1 on 5/20/2024, with diagnoses that included unspecified (unconfirmed) sepsis (a serious condition in which the body responds improperly to an infection), generalized muscle weakness and right ankle and foot Charcot ' s joint (a rare complication that happens when diabetes [uncontrolled elevated blood sugar] damages nerves in your lower legs and feet).</p> <p>During a record review of Resident 1 ' s History and Physical (H&amp;P), dated 5/20/2024, the H&amp;P indicated Resident 1 had the capacity to understand and make decisions.</p> <p>During a record review of Resident 1 ' s Minimum Data Set (MDS - a standardized assessment and care screening tool) dated 5/27/2024, the MDS indicated resident ' s cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were intact. The MDS indicated Resident 1 required moderate assistance from staff for all activities of daily living (ADL-oral hygiene, toileting, personal hygiene and transferring).</p> <p>During a record review of Resident 1 ' s Order Summary Report dated 5/20/2024, it indicated a physician ' s order for carbohydrate controlled (means that meals contain carbohydrate-rich foods in fairly equal amounts), no added salt regular texture diet.</p> <p>During a record review of Resident 1 ' s Interdisciplinary Team (IDT- a coordinated group of experts from several different fields who work together) Progress Note dated 8/13/2024, it indicated Resident 1 preferred to order food from outside of the facility.</p> <p>During an interview on 8/19/2024 at 8:51 a.m., with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated Resident 1 goes out of the facility to buy food.</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 - Few</p>	<p>During an interview on 8/19/2024 at 9:37 a.m., the Dietary Supervisor (DS), the DS stated she (DS) was not aware that Resident 1 orders food from outside of the facility.</p> <p>During an interview on 8/19/2024 at 10:35 a.m., with the Assistant Director of Nursing (ADON), the ADON stated Resident 1 was noncompliant with the physician prescribed diet and buys out side food. The ADON stated there is no care plan created addressing Resident 4 ' s preference for outside food. The ADON stated staff should be aware of foods brought in to ensure the diet ordered by the physicain is followed.</p> <p>During a record review of facility ' s policy and procedure titled, Foods Brought/Bought by Residents/family/Visitors, dated 2/2014 indicated, Staff must be aware of, and approve, food(s) brought to a resident by family/visitors or bought by a resident from the outside. The Dietitian or a Nurse Supervisor should assure that the food is not in conflict with the resident's prescribed diet plan.</p> <p>During a record review of facility ' s PnP titled, Comprehensive Assessment and the Care Delivery Process dated 12/2016, the PnP indicated, Comprehensive assessments, care planning and the care delivery process involve collecting and analyzing information, choosing and initiating interventions, and then monitoring results and adjusting interventions.</p> <p>During a record review of facility ' s PnP titled, Resident on Leave or Pass, dated 4/2022, indicated, The food services department shall be notified when a resident will be away from the facility during scheduled mealtimes. Nursing services will notify the food services department when a resident will be away from the facility during mealtimes. Notification will be in writing unless time constraints require verbal notification. Such information will include, but is not necessarily limited to:</p> <ul style="list-style-type: none"> <li>a. which meal(s) the resident will miss.</li> <li>b. how long the resident will be absent; and</li> <li>c. which meal the resident will be served upon returning to the facility.</li> </ul>		

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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>42311</p> <p>Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1) had a physician ' s order for out on pass (leave the facility for a period of time and then come back to continue their treatment. Out on pass is requested by the patients or residents and signed by the treating team. It is granted to the patient after clinical assessment) before Resident 1 was allowed to go out of the facility unsupervised.</p> <p>This deficient practice had the potential to place Resident 1 at risk for injuries resulting from accidents.</p> <p>Findings:</p> <p>During a record review of Resident 1 ' s Admission Record, it indicated the facility admitted Resident 1 on 5/20/2024, with diagnoses that included unspecified (unconfirmed) sepsis (a serious condition in which the body responds improperly to an infection), generalized muscle weakness and right ankle and foot Charcot ' s joint (a rare complication that happens when diabetes [uncontrolled elevated blood sugar] damages nerves in your lower legs and feet).</p> <p>During a record review of Resident 1 ' s History and Physical (H&amp;P) dated 5/20/2024, the H&amp;P indicated Resident 1 had the capacity to understand and make decisions.</p> <p>During a record review of Resident 1 ' s Minimum Data Set (MDS - a standardized assessment and care screening tool) dated 5/27/2024, the MDS indicated resident ' s cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were intact. The MDS indicated Resident 1 required moderate assistance from staff for all activities of daily living (ADL-oral hygiene, toileting, personal hygiene and transferring). The MDS indicated Resident 1 was occasionally incontinent (unable to control) of bowel and bladder functions.</p> <p>During a record review of Resident 1 ' s Order Summary Report dated 5/20/2024, it indicated an order for non-weight bearing (for a certain period of time following injury or surgery you are not allowed to put any weight through the operated or injured limb to allow it to heal) on right lower extremity.</p> <p>During a record review of Resident 1 ' s Interdisciplinary Team (IDT- a coordinated group of experts from several different fields who work together) Care Conference Notes dated 5/31/2024, it indicated Resident 1 required moderate assists from staff for most ADL ' s.</p> <p>During a record review of Resident 1 ' s Interdisciplinary Team Progress Note dated 8/13/2024, it indicated an IDT meeting was conducted with Long Term Care Ombudsman (OMB- a person that assist residents in long-term care facilities with issues related to day-to-day care, health, safety, and personal preferences). The IDT Progress Note indicated per OMB, Resident 1 had the right to leave the facility whether he had a physician order or not as long as he signs out, on the Out on Pass Binder with expected time of return.</p> <p>(continued on next page)</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>During a record review of Resident 1 ' s Temporary Leave of Absence log dated 8/2024, it indicated Resident 1 left the facility unsupervised eight times with no documented expected time of return on the following dates: 8/5/2024, 8/15/2024, 8/16/2024 and 8/17/2024.</p> <p>During an interview on 8/19/2024 at 8:51 a.m., Licensed Vocational Nurse 1 (LVN 1) stated Resident 1 had always wanted to leave the facility unsupervised. LVN 1 stated Resident 1 uses wheelchair when leaving the facility.</p> <p>During a concurrent interview and record review on 8/19/2024 at 10:35 a.m., with the Assistant Director of Nursing (ADON), Resident 1 ' s Physician Orders was reviewed. The ADON stated there were no physician order for Resident 1 to go out on pass unsupervised.</p> <p>During a concurrent interview and record review on 8/19/2024 at 11.44 a.m., with the ADON, Resident 1 ' s Progress Notes dated 8/2024 and Temporary Leave of Absence log dated 8/2024 was reviewed. The ADON stated there was no documented expected time of Resident 1's return on the following dates: 8/5/2024, 8/15/2024, 8/16/2024 and 8/17/2024. The ADON stated on 8/12/2024 there was no documented time Resident 1 came back to the facility. The ADON stated nurses should document in Progress Note, the time Resident 1 left the facility and the time Resident 1 returned to the facility to ensure resident safety. The ADON stated Resident 1 was placed at risk for accident when the resident was allowed to leave the facility unsupervised without a physician's order.</p> <p>During a concurrent interview and record review of facility ' s policy and procedure (PnP) titled, Residents on Leave or Pass dated 4/2022 indicated, The resident may go out on pass with the physician ' s order. Nursing services will inform the physician of the resident's desire to go out on pass or leave. Resident will be notified of the order. Resident will sign out before leaving the facility and sign back in upon arrival to the facility. The ADON stated their policy is to obtain a physician ' s order first before allowing Resident 1 to leave the facility unsupervised.</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>Provide and implement an infection prevention and control program.</p> <p>42311</p> <p>Based on observation, interview and record review, the facility failed to implement infection control measures for one of three sampled residents (Resident 3) by failing to ensure Transporter 2 wore facemask while picking up Resident 3 for an appointment on 8/19/2024, when the facility had one staff who tested positive Coronavirus Disease 2019 (COVID-19, highly contagious respiratory disease is thought to spread from person to person through droplets released when an infected person coughs, sneezes or talks) on 8/17/2024.</p> <p>This deficient practice had the potential for spread COVID-19 among residents and staff.</p> <p>Findings:</p> <p>During a record review of Resident 3 ' s Admission Record, it indicated the facility admitted Resident 3 on 3/29/2024 with diagnoses that included other toxic encephalopathy (indicate brain dysfunction caused by toxic exposure), diabetes mellitus (uncontrolled elevated blood sugar) and unspecified (unconfirmed) dementia (the loss of cognitive functioning, thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities).</p> <p>During a record review of Resident 3 ' s History and Physical (H&amp;P) dated 3/30/2024, the H&amp;P indicated Resident 3 can make needs known but could not make medical decisions.</p> <p>During a record review of Resident 3 ' s Minimum Data Set (MDS - a standardized assessment and care screening tool) dated 4/5/2024, the MDS indicated resident ' s cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired.</p> <p>During a record review of Resident 3 ' s Physician Order dated 8/13/2024, it indicated an order for a dental appointment at 1 p.m., with scheduled pick up at 11:45 a.m.</p> <p>During a concurrent observation and interview on 8/19/2024 at 12:09 p.m., with Licensed Vocational Nurse 2 (LVN 2), in front of Nurses Station. Observed Transporter 2 not wearing a facemask while transferring Resident 3 from the wheelchair to the gurney (a wheeled stretcher used for transporting hospital patients). LVN 2 stated Transporter 2 should have worn a facemask while inside the facility. Observed LVN 2 talked to Transporter 2 and provided Transporter 2 with a facemask.</p> <p>During an interview on 8/19/2024 at 12:10 p.m., Transporter 2, Transporter 2 stated they came in from the back entrance of the facility and was not informed to wear a facemask inside the facility.</p> <p>During an interview on 8/19/2024 at 12:11 p.m., with the Infection Preventionist (IP), the IP stated they have one staff who tested positive for COVID -19 on 8/17/2024. The IP stated the facility's policy for masking is for staff and transport personnel to wear a facemask when inside the facility to prevent spread of COVID-19.</p> <p>(continued on next page)</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>During a record review of facility ' s policy and procedure (PnP) titled, Personal Protective Equipment-Face Mask/ N95 (a respiratory protective device designed to achieve a very close facial fit and very efficient filtration of airborne particles) dated 7/2024 indicated The facility permits universal use of facemask and N95 respirators to minimize exposure to droplet and airborne contaminants including severe acute respiratory syndrome coronavirus 2 (SARsCoV2- a strain of coronavirus that causes COVID-19, the respiratory illness responsible for the COVID-19 pandemic [global outbreak]). Healthcare personnel must wear N95 respirator or surgical face mask when entering the facility. Transport personnel must wear face covering and other required PPE when indicated.</p>		