Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	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)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 42311 Based on interview and record review, the facility failed to report allegation of staff-to-resident abuse within two hours to the State Survey Agency (SSA) and the Ombudsman (an advocate for residents of nursing homes, board and care centers, and assisted living facilities), as per its policies on abuse for one of three sampled residents (Resident 1). This deficient practice had the potential to place Resident 1 at risk for further abuse. Findings: During a record review of Resident 1's Admission Record, the Admission Record indicated the facility admitted Resident 1 on 5/18/2021, with diagnoses that included unspecified (unconfirmed) atrial fibrillation (irregular heartbeat), essential hypertension (a type of high blood pressure that develops gradually and has no clear cause) and Alzheimer's disease (a disease characterized by a progressive decline in mental abilities). During a record review of Resident 1's History and Physical (H&P), dated 5/26/2024, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a record review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 12/25/2024, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 1 was dependent to staff for all activities of daily living (ADL-eating, toileting, dressing and personal hygiene). During a record review of Resident 1's Situation Background Assessment Review (SBAR-a communication tool used by healthcare workers when there is a change of condition among the residents) Communication Form, dated 1/7/2025, the SBAR indicated Resident 1 had minor bruising and minor swelling on the left hand near the knuckles of the second and third finger. The SBAR indicated the Physician was notified on 1/7/2025 a 6 p.m. (continued on next page)

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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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of Resident 1's Progress Notes (PN), dated 1/7/2025, timed at 10 pm., the PN indicated Registered Nurse 1 (RN 1) called Family Member 1 (FM 1) and FM 1 notified RN 1 that FM 1 believed that either Home Health Aide (HHA) or Certified Nursing Assistant 4 (CNA 4) mishandled Resident 1 during care. The PN indicated RN 1 notified FM 1 that she (RN 1) would investigate the incident. During an interview on 1/9/2025, at 2:02 p.m., with Caregiver (CG) and translated by the Activity Director (AD), CG stated on 1/7/2025, at 11 a.m., in the dining room, Resident 1 reported to CG the redness on Resident 1's left hand. CG stated she (CG) reported to CNA 3 on 1/7/2025, between 3 p.m., to 4 p.m., and Licensed Vocational Nurse 2 (LVN 2) came to check Resident 1 between 4 p.m., to 5 p.m. During an interview on 1/9/2025, at 3:09 p.m., the Director of Nursing (DON) stated bruising and redness was observed on 1/7/2025, at 6 p.m. The DON stated she (DON) was not notified of the change in condition on 1/7/2025. The DON stated any staff can report allegation of abuse to Administrator (ADM) and the facility's policy was to report allegation of abuse within two hours. During an interview on 1/9/2025, at 3:45 p.m., the ADM stated FM 1 reported Resident 1's allegation of abuse on 1/8/2025, at 9:45 a.m. The ADM stated she (ADM) called SSA on 1/8/2025 at 10:36 a.m. to report the allegation of abuse. During an interview on 1/9/2025, at 4:11 p.m., CNA 3 stated on 1/7/2025, at 5:30 p.m., CG informed and showed her (CNA 3) Resident 1's redness on the left hand. CNA 3 instructed CG to call LVN 2 while she (CNA 3) stayed with Resident 1. CNA 3 stated LVN 2 came and looked at Resident 1's hand. During an interview on 1/14/2025, at 11:17 a.m., LVN 2 stated on 1/7/2025 between 6:30 p.m., to 7 p.m., FM 1 called and spoke to LVN 2, FM 1 reported to LVN 2 that somebody hurt Resident 1. LVN 2 stated she (LVN 2) reported to RN 1 that FM 1 was upset and claimed somebody hurt Resident 1. LVN 2 stated she (LVN 2) should have reported to the ADM within two hours after FM 1 notified her (LVN 2) that somebody hurt Resident 1. During a record review of facility's policy and procedure (PP) titled, Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating dated 4/2021 and last reviewed on 1/2025, the PP indicated, All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft, misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. 1. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. 2. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing or certification agency responsible for surveying or licensing the facility. b. The local or state ombudsman. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. The resident's representative. d. Adult protective services (where state law provides jurisdiction in long-term care). e. Law enforcement officials. f. The resident's attending physician; and g. The facility medical director. 3. Immediately is defined as: a. within two hours of an allegation involving abuse or result in serious bodily injury; or b. within 24 hours of an allegation that does not involve abuse or result in serious bodily injury. During a record review of facility's policy and procedure (PP) titled, Abuse, Neglect, exploitation and Misappropriation Prevention dated 4/2021 and last reviewed on 1/2025, the PP indicated, Investigate and report any allegations within timeframes required by federal requirements.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 42311 Based on interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) for one of three sampled residents (Resident 1) by not following the physician's orders. This deficient practice had the potential to result in Resident 1 receiving too much pain medication causing overdose (happens when a toxic amount of a drug, or combination of drugs overwhelms the body). Findings: During a record review of Resident 1's Admission Record, the Admission Record indicated the facility admitted Resident 1 on 5/18/2021, with diagnoses that included unspecified (unconfirmed) atrial fibrillation (irregular heartbeat), essential hypertension (a type of high blood pressure that develops gradually and has no clear cause) and Alzheimer's disease (a disease characterized by a progressive decline in mental abilities). During a record review of Resident 1's History and Physical (H&P), dated 5/26/2024, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a record review of Resident 1's Care Plan on at risk for alteration in comfort, dated 5/27/2024, the Care Plan indicated an intervention to administer pain medication as ordered. During a record review of Resident 1's Order Summary Report, dated 7/16/2024, the Order Summary Report indicated ibuprofen (medication used to treat pain) 600 milligrams (mg- metric unit of measurement, used for medication dosage and or amount), give one tablet by mouth every six hours as needed for moderate pain level of four to six. During a record review of Resident 1's Order Summary Report, dated 12/20/2024, the Order Summary Report indicated hydrocodone-acetaminophen (medication used to treat pain) 5-325 mg, give two tablets by mouth every six hours as need for severe pain level of eight to ten. During a record review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 12/25/2024, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 1 was dependent to staff for all activities of daily living (ADL-eating, toileting, dressing and personal hygiene). (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 1/9/2025, at 3:09 p.m., with the Director of Nursing (DON), Resident 1's Order Summary Report dated 7/16/2024, 12/20/2024, and Medication Administration Record (MAR- a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) dated 1/2025, was reviewed. The MAR dated 1/6/2025, indicated at 9:34 a.m. , Licensed Vocational Nurse 3 (LVN 3) gave two tablets of hydrocodone-acetaminophen to Resident 1 with a pain level of seven. The DON stated Resident 1 should have been given ibuprofen instead of hydrocodone-acetaminophen. The DON stated LVN 3 did not follow the physician's order. During a record review of facility's policy and procedure (PP) titled, Administering Medications, dated 12/2012, and last reviewed on 1/2025, the PP indicated, Medications shall be administered in a safe and timely manner, and as prescribed. 3. Medications must be administered in accordance with the orders, including any required time frame. During a record review facility's PP titled, Pain Assessment and Management, dated 3/2020, and last reviewed on 1/2025, the PP indicated, The pain management program is based on a facility-wide commitment to appropriate assessment and treatment of pain, based on professional standards of practice, the comprehensive care plan, and the resident's choices related to pain management.