

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 05/14/2025
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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43497</p> <p>Based on interview and record review, the facility failed to ensure code pink (the facility's code to call when a resident is missing) was called immediately when one of three sampled residents (Resident 1) was missing per facility's undated policy and procedure titled, Missing Resident,.</p> <p>This deficient practice resulted in Resident 1 missing medications placing Resident 1 at risk for potential harm.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was admitted on [DATE] with diagnoses including metabolic encephalopathy (a brain dysfunction resulting from underlying metabolic or systemic issues), muscle weakness, diabetes type 2 (high blood sugar), anemia (lack of blood), duodenal ulcer (a sore that develops on the lining of the intestine), post-traumatic stress disorder (a disorder in which a person has difficulty recovering after experiencing a terrifying event), history of falling, polyneuropathy (nerve damage), and failure to thrive (a gradual decline in health).</p> <p>During a review of Resident 1's Minimum Data Set (MDS - a standardized resident assessment tool), dated 2/18/2025, the MDS indicated Resident 1 had moderately impaired cognition. Resident 1 required supervision with eating, and partial assistance with oral hygiene, toileting, and dressing.</p> <p>During a review of Resident 1's Progress Notes, dated 5/6/2025 at 9:15pm., the Progress Notes indicated the following:</p> <ul style="list-style-type: none"> - On 5/6/2025 at 9 :15 pm, Licensed Vocational Nurse (LVN) 1 checked Resident 1's blood sugar with blood sugar of 262 with orders to call Medical Doctor if blood sugar was less than 60 or greater than 250. Family Member (FM) 1 was sitting next to Resident 1. At that time, FM 2 came in to see Resident 1. - On 5/6/2025 at 9: 20 pm, LVN 1 left Resident 1's room and went to Registered Nurse (RN) 1 to inform Resident 1's blood sugar. Per RN 1, she would inform Resident 1's Nurse Practitioner (NP). - On 5/6/2025 at 9:25 pm, RN 1 informed LVN 1 of new orders from the NP which was to give Humulin insulin (medication used to control blood sugar) 6 units times one for blood sugar greater than 250 and encourage to drink more fluids. <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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- On 5/6/2025 at 9:30 p.m., LVN 1 went back to Resident 1's room after preparing the medication (Humulin insulin). LVN 1 unable to find Resident. LVN 1 checked the bathroom. LVN 1 checked inside the building. LVN 1 did not find Resident 1 or Family Member (FM 1).</p> <p>- On 5/6/2025 at 10 p.m., LVN 1 informed RN 1. RN 1 paged code pink. Staff looked for Resident 1 inside and outside the building. LVN 1 and RN 1 went to the nearest gas station. RN 1 called the Administrator and Director of Nurses (DON) to notify Resident 1 was unable to be located. RN 1 called the maintenance supervisor to check the camera. RN 1 called the police to report a missing person (Resident 1).</p> <p>- On 5/6/2025 at 10:30 p.m., Maintenance Supervisor checked the (main entrance) camera. Resident 1 and FM 1 were noted exiting the front lobby at around 9:51 p.m.</p> <p>- On 5/6/2025 at 11:15 p.m., five police officers came to the facility. Resident 1's Durable Power of Attorney (FM 3) arrived at the front lobby.</p> <p>- On 5/6/2025 at 11:45 p.m., LVN 1 went back to Resident 1's room and noted all of Resident 1's belongings in the room. A light blue notebook with medication list was missing.</p> <p>During an interview with Registered Nurse (RN 1) on 5/13/2025 at 4:07 p.m., RN 1 stated, on 5/6/2025 at around 9:20 p.m., LVN 1 reported that Resident 1's blood sugar was 262, and there was an order to call the Medical Doctor for blood sugar greater than 250. RN 1 stated, she received an order from the Nurse Practitioner (NP) to give Resident 1 an order for 6 units of insulin. RN 1 stated, she notified LVN 1 of the new order. RN 1 stated, at around 10 p.m., LVN 1 reported that Resident 1 was missing. RN 1 stated she called code pink. RN 1 stated code pink is a code used in the facility to notify the staff that a resident is missing. RN1 stated she notified the Administrator and the DON. RN 1 stated she called the police, but they were not answering so she (RN 1) called 911. RN 1 stated she tried calling FM 1 several times, and FM 1 never picked up the phone. RN 1 stated when a resident goes missing, they (facility staff) look if the missing resident is anywhere in the facility such as a bathroom, or the patio. RN 1 stated the facility needs to call code pink as soon as the facility realizes that a Resident is missing. RN 1 stated it should not have taken 30 minutes to call the code pink when Resident 1 went missing. RN 1 stated Resident 1 left the facility without getting the dose of insulin, and this resulted in Resident 1 to not get treated for the elevated blood sugar.</p> <p>During an interview with LVN 1 on 5/13/2025 at 4:50 p.m., LVN 1 stated when she (LVN 1) noted that Resident 1 was not in her (Resident 1) room, she (LVN 1) went around the facility, and it took her 30 minutes to look everywhere inside the building. LVN 1 stated she panicked and started looking for Resident 1 by herself. LVN 1 stated when she could not find Resident 1 that is when she told RN 1. LVN 1 stated code pink should have been called when she realized Resident 1 was missing. LVN 1 stated it should not have taken 30 minutes to call code pink when Resident 1 went missing.</p> <p>During an interview with the DON on 5/14/2025 at 3:30 p.m., the DON stated Resident 1 left the facility without proper authorization or notice. The DON stated the potential outcome was the uncertainty about Resident 1's safety and concerns on medication continuity. The DON stated after multiple attempts to reach FM 1, FM 1 texted back that Resident 1 was doing well, and Resident 1's blood sugar was stable (Note: The DON have not seen Resident 1 and have not seen any documented evidence of FM 1 monitoring Resident 1's blood sugar).</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's policy and procedure titled, Elopements, dated 5/3/2022, the policy and procedure indicated, Staff shall promptly report any resident who . is suspected of being missing to the Charge Nurse, RN Supervisor or Director of Nursing.</p> <p>During a review of the facility's policy and procedure titled, Missing Resident, undated, the policy and procedure indicated, if a potential missing resident is identified the following actions will be implemented immediately: Immediate response to announce code pink.</p> <p>During a review of the facility's policy and procedure titled, Quality of Care, dated 10/2024, the policy and procedure indicated each resident shall be cared for in a manner that promotes and enhances quality care. Quality healthcare can be defined in many ways but there is growing acknowledgment that quality health services should be effective, safe, and resident-centered.</p>