

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/02/2026
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)		
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review, the facility failed to communicate accurate information to the receiving provider (GACH - General Acute Care Hospital) regarding resident's medication administration record for one of three sampled residents (Resident 1). On 5/19/2026, Resident 1 was transferred to GACH1 for a surgical procedure to be performed under the anesthesia (a medicine that stops the person from feeling pain signals from the nerves in the brain). This deficient practice resulted in rescheduling a surgical procedure and had the potential to negatively affect Resident 1's health and well-being. Findings: During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted Resident 1 on 1/21/2026 with diagnoses including metabolic encephalopathy (a brain dysfunction caused by a chemical imbalance that can cause confusion), unspecified dementia (a progressive state of decline in mental abilities), diabetes mellitus type two (DM II - a disorder characterized by difficulty in blood sugar control and poor wound healing), and epilepsy (a chronic neurological disorder characterized by recurrent, unprovoked seizures [a sudden, uncontrolled electrical disturbance in the brain]). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 4/27/2026, the MDS indicated Resident 1 had moderately impaired cognitive functioning (mental processes that enable people to think, understand, make decisions, and complete tasks). The MDS indicated Resident 1 required partial/moderate assistance (helper does less than half of the effort) with toileting hygiene, showers, and upper and lower body dressing. The MDS indicated Resident 1 required supervision or touching assistance (helper provides verbal cues and/or touching assistance as resident completes the activity) with ambulating 150 feet (ft - a unit of measurement). During a review of Resident 1's History and Physical Note (H&P - a comprehensive assessment of a resident's medical condition), dated 5/11/2026, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1's Order Summary Report (OSR), the OSR indicated the following physician's orders:- Ozempic subcutaneous solution pen-injector (a medication administered via a pre-filled, multi-dose subcutaneous [fatty tissue layer beneath the skin] pen injector used to lower blood sugar), 2 (two) milligrams (mg - a unit of measurement)/3 milliliters (ml - a unit of measurement) with the instruction to inject 0.5 mg subcutaneously in the morning every Monday related to DM II.- Surgery for EUA (EUA - an examination under anesthesia), EXP laparoscopy (an exploratory surgery using a lighted scope, tiny incisions, and a camera), TAH-BSO (a total abdominal hysterectomy with bilateral salpingo-oophorectomy, the complete removal of the uterus, cervix, both ovaries, and both fallopian tubes [female reproductive system organs]), with possible omentectomy (the removal of the fatty tissue that covers the intestines and stomach), LND (LND - lymph node dissection [the surgical removal and sampling of lymph nodes in the pelvis and abdomen to check for cancer spread]) appendectomy (the removal of the appendix), and radical debulking (removal of as much visible tumor tissue and disease as safely possible throughout the abdomen) scheduled on 5/19/2026 at 1:30 p.m. During a review of Resident 1's Medication Administration Record (MAR) from 5/1/2026 to 5/31/2026, the MAR indicated:-Ozempic subcutaneous solution pen-injector, 2 mg/3 milliliters with the instruction to inject 0.5 mg subcutaneously in the morning every Monday related to DM II. The (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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MAR indicated to hold medication from 5/12/2026 to 5/19/2026. During a concurrent interview and record review on 6/2/2026 at 12:50 p.m. with Registered Nurse (RN) 1, Resident 1's Progress Note, dated 5/19/2026 was reviewed. The Progress Note indicated that on 5/19/2026 at 11:22 a.m., RN 1 received a call from GACH 1 provider to clarify the last administration time for Resident 1's Ozempic. The Progress Note indicated that initially, RN 1 informed GACH provider that Resident 1's last Ozempic administration date was 5/18/2026 but later, during a follow up call, RN 1 clarified that the medication was on hold and was not administered on 5/18/2026. The Progress Note indicated that the GACH 1 provider informed RN 1 that the surgery would be rescheduled. RN 1 stated that prior to transferring Resident 1 to GACH 1 for surgery, Resident 1's medication orders were communicated with the GACH provider. RN 1 stated there was no documented evidence to indicate that Resident 1's medication administration times were communicated with GACH 1 provider prior to the scheduled surgery. During an interview on 6/2/2026 at 4:43 p.m. with the Director of Nursing (DON), the DON stated Resident 1's medication administration times should have been included in Resident 1's transfer paperwork. The DON stated the best practice was to document in the transfer communication forms medication administration record as well. The DON stated that on 5/19/2026 RN 1 offered to provide the medication administration times to the GACH 1 provider during the phone conversation, but GACH 1 provider decided to reschedule Resident 1's surgery. The DON stated there was no documented evidence to indicate facility staff provided Resident 1's medication administration record to GACH 1 provider prior to Resident 1's scheduled surgery. The DON stated Resident 1 had the potential to experience delays in further diagnoses and necessary treatment. During a review of the facility's policy and procedure (P&P) titled, Transfer or Discharge, Resident-Initiated, revised on 1/2026, the P&P indicated, 1. 'Transfer' refers to the movement of a resident from a bed in one certified facility to a bed in another certified facility when the resident expects to return to the original facility. Information Conveyed to Receiving Provider section indicated: If the resident is being transferred, and return is expected, the following information is conveyed to the receiving provider. f. All other information necessary to meet the resident's needs, which includes, but may not be limited to. (4) medications (including when last received).		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on interview and record review, the facility failed to follow physician orders for nothing by mouth (NPO- resident should not consume any food, beverages, or oral medication. It is commonly used for safety before surgery or procedures that require anesthesia to prevent serious complications) for one of three sampled residents (Resident 1). These deficient practices had the potential to delay care and negatively affect Resident 1's health and well-being. Findings: During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted Resident 1 on 1/21/2026 with diagnoses including metabolic encephalopathy (a brain dysfunction caused by a chemical imbalance that can cause confusion), unspecified dementia (a progressive state of decline in mental abilities), diabetes mellitus type two (DM II - a disorder characterized by difficulty in blood sugar control and poor wound healing), and gastroesophageal reflux disease (GERD - a chronic digestive condition where stomach acid repeatedly flows back into the esophagus [a muscular tube that connects the mouth and throat to the stomach]). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 4/27/2026, the MDS indicated Resident 1 had moderately impaired cognitive functioning (mental processes that enable people to think, understand, make decisions, and complete tasks). The MDS indicated Resident 1 required partial/moderate assistance (helper does less than half of the effort) with toileting hygiene, showers, and upper and lower body dressing. The MDS indicated Resident 1 required supervision or touching assistance (helper provides verbal cues and/or touching assistance as resident completes the activity) with ambulating 150 feet (ft - a unit of measurement). During a review of Resident 1's History and Physical Note (H&P - a comprehensive assessment of a resident's medical condition), dated 5/11/2026, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1's Order Summary Report (OSR), the OSR indicated the following physician's orders:- Famotidine (a medication that reduces stomach acid production) oral tablet 20 milligram (mg - a unit of measurement) with the instructions to give 1 (one) tablet by mouth in the morning for GERD. The order indicated to administer on an empty stomach before breakfast. The OSR indicated an order date of 4/4/2026.- Nothing by mouth (NPO) at midnight on 5/19/2026 before procedure. The order indicated it is ok to give blood pressure medication with small sip of water before procedure. The OSR indicated an order date of 4/30/2026.- Surgery for EUA (EUA - an examination under anesthesia), EXP laparoscopy (an exploratory surgery using a lighted scope, tiny incisions, and a camera), TAH-BSO (a total abdominal hysterectomy with bilateral salpingo-oophorectomy, the complete removal of the uterus, cervix, both ovaries, and both fallopian tubes [female reproductive system organs]), with possible omentectomy (the removal of the fatty tissue that covers the intestines and stomach), LND (LND - lymph node dissection [the surgical removal and sampling of lymph nodes in the pelvis and abdomen to check for cancer spread]) appendectomy (the removal of the appendix), and radical debulking (removal of as much visible tumor tissue and disease as safely possible throughout the abdomen) scheduled on 5/19/2026 at 1:30 p.m. The OSR indicated an order date of 5/1/2026. During a review of Resident 1's Medication Administration Record (MAR) from 5/1/2026 to 5/31/2026, the MAR indicated:- Famotidine oral tablet 20 milligram to give 1 (one) tablet by mouth in the morning for GERD. The order indicated to administer on an empty stomach before breakfast. The OSR indicated to hold the medication on 5/19/2026. During a concurrent interview and record review on 6/2/2026 at 12:50 p.m. with Registered Nurse (RN) 1, Resident 1's MAR, dated 5/2026, was reviewed. The MAR indicated, on 5/19/2026, Resident 1's Famotidine was administered. RN 1 stated the facility staff should have held Resident 1's Famotidine for the 9 a.m. administration time. RN 1 stated Resident 1 could potentially experience adverse side effects and complications during the surgery. During an interview on 6/2/2026 at 3:26 p.m. with the Director of Nursing (DON), the DON stated that the facility staff should have reviewed each medication order, including Famotidine order, and updated with orders on when to hold. The DON stated the failure to hold famotidine on 5/19/2026, had the potential (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to delay Resident 1's surgery and care. During a review of the facility's policy and procedure (P&P) titled, Physician Orders, last revised on 1/2026, the P&P indicated, Verbal, written and telephone orders may be accepted from each resident's Attending Physician. The P&P indicated, New order/s will be communicated to the responsible party/agent, charge nurse, pharmacy, other department/s as indicated. During a review of the facility's policy and procedure (P&P) titled, Administering Medications last revised on 1/2026, the P&P indicated, Medications are administered in accordance with prescriber orders, including any required time frame.		

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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. Based on interview and record review, the facility failed to ensure the medical records for one of three sampled residents (Resident 2) were complete and accurate and were maintained in accordance with accepted professional standards and practice. The facility failed to: 1. Ensure complete documentation of Resident 2's Situation, Background, Assessment, and Recommendation Communication (SBAR) form, dated 5/19/2026. 2. Ensure accurate documentation of Resident 2's Fall Risk Assessment (a tool to identify residents at high risk of falling by evaluating factors such as medical conditions, history of falls, vision, balance, mobility, medications) form. These deficient practices had the potential for inaccurate documentation and inaccurate medical interventions for Resident 2. Findings: During a review of Resident 2's admission Record (AR), the AR indicated the facility admitted Resident 2 on 5/12/2026 with diagnoses including heart failure (a heart disorder which causes the heart not to pump the blood efficiently to meet body's needs), muscle weakness, and lack of coordination. During a review of Resident 2's History and Physical Examination (H&P - a comprehensive assessment of a resident's medical condition), dated 5/13/2026, the H&P indicated Resident 2 had the capacity to understand and make decisions. During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated 5/16/2026, the MDS indicated Resident 2 had intact cognitive functioning (mental processes that enable people to think, understand, make decisions, and complete tasks). The MDS indicated Resident 2 required maximal assistance (helper does more than half of the effort) with eating, oral hygiene, and personal hygiene. The MDS indicated Resident 2 was dependent (helper does all the effort) for toileting hygiene and showers. During a concurrent interview and record review on 6/2/2026 at 3:26 p.m. with the Director of Nursing (DON), Resident 2's SBAR Communication Form, dated 5/19/2026, was reviewed. The SBAR Communication Form indicated that on 5/19/2026, the facility staff found Resident 2 on the floor, sitting next to Resident 2's bed with a laceration on the right side of Resident 2's head. The SBAR Communication Form indicated that the facility staff provided treatment for Resident 2's head laceration. The DON stated the SBAR Communication Form did not include description of the laceration or the type of treatment that was provided to Resident 2. The DON stated there was no documented evidence describing the details of Resident 2's laceration or the treatment Resident 2 was received. The DON stated the facility staff should have documented the presentation of the laceration such as the measurements and the amount of drainage, as well as the kind of treatment provided to Resident 2. The DON stated it was important to have a baseline description of the injury to assess the healing process. The DON stated failure to have complete documentation of Resident 2's head laceration had the potential to affect the course of treatment since the facility staff would not know if Resident 2's laceration was responding to the treatment. During a concurrent interview and record review on 6/2/2026 at 3:45 p.m. with the DON, Resident 2's Fall Risk Assessment Form, dated 5/19/2026, was reviewed. The Fall Risk Assessment form indicated Resident 2 did not have episodes of fall in the past three months. The DON stated the Fall Risk Assessment form was one of the facility's tools to identify residents with high risk of fall and provide necessary interventions to prevent falls. The DON stated the assessment form generates a score based on the answers to the questions listed on the form. The DON stated Resident 2's Fall Risk Assessment form, dated 5/19/2026, was completed after Resident 2's fall episode. The DON stated Resident 2's Fall Risk Assessment Form should have included Resident 2's fall episode on 5/19/2026. The DON stated failure to accurately document Resident 2's Fall Risk Assessment had the potential to affect interventions necessary to prevent falls for Resident 2. During a review of facility's policy and procedure (P&P) titled, Charting and Documentation, last reviewed on 1/2026, the P&P indicated, All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. The Policy Interpretation and Documentation section indicated:2. The following information is to be documented in the resident medical record.a. objective observations.c. Treatments or services performed. 3. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.7. Documentation of procedures and treatment will include care-specific details, including.c. the assessment date, and/or any unusual findings obtained during the procedure/treatment.		